

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14084

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13976

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Boyd's</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>H.</u> Middle <u>Adams</u> Last		4. DATE OF DEATH <u>Dec. 6</u> Month <u>Dec.</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul. 18, 1891</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Addison E. DUFFIN</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Nolan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>022-22-55</u>	
17. INFORMANT <u>Edna Johnson, Sister</u>		Address <u>Boyd's, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia, Bilateral</u> Conditions, if any, which gave rise to immediate cause (b) <u>Metastatic Pulmonary Adenocarcinoma</u> cause (c), stating the underlying cause lost. <u>Primary Adenocarcinoma Uterus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-10, 1959</u> to <u>12-6, 1960</u> , that (II) (we) last saw the deceased alive on <u>12-5, 1960</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Clare G. Jackson</u>		22b. DATE SIGNED <u>12-6-60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>202 Martin Lane, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMAINS (Specify) <u>SHIPPED</u>		23b. DATE THEREOF <u>12/10/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CHISOLM FUNERAL CHAPEL.,</u>		23d. LOCATION (City, town, or county) (State) <u>BOSTON, MASS.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>ROCKVILLE, MD.</u>	
25a. REC'D BY REGISTRAR <u>DEC 12 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Knecht</u>	

838

DEPARTMENT OF HEALTH
CENTRAL OFFICE

14084

PO 1921

CHIEF CLERK

14085

CERTIFICATE OF DEATH

Reg. Dist. No. 13977

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				d. STREET ADDRESS 1824 Philadelphia Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anthony Middle D Last Alexander				4. DATE OF DEATH Month Dec Day 22 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2/1884	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76		IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. Son (B.R. Alexander)				17. INFORMANT Address Son (B.R. Alexander)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JAN , 1955, to 12/22 , 19 60 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 780I Norfolk Ave, Bethesda. Md. DATE SIGNED DEC 28 '60							
ACTUAL SIGNATURE Dr. John M Wyman M.D.				PHYSICIAN'S NAME (Type) Dr. John M Wyman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-26-60			
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill				22d. LOCATION (City, town, or county) (State) Front Royal, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Madley Funeral Home, Front Royal ADDRESS Front Royal, Virginia				24a. REC'D BY REGISTRAR DEC 28 '60			
24b. REGISTRAR'S SIGNATURE Charles L. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1987

1. PLACE OF DEATH Home		2. SEX Male	
3. DATE OF DEATH 10/10/87		4. TIME OF DEATH 10:00 AM	
5. CITY OR TOWN OF DEATH Baltimore		6. COUNTY OF DEATH Baltimore	
7. STATE OF DEATH Maryland		8. ZIP CODE 21201	
9. NAME OF DECEASED John Doe		10. DATE OF BIRTH 01/01/20	
11. SEX OF DECEASED Male		12. RACE White	
13. OCCUPATION Teacher		14. MARITAL STATUS Married	
15. PLACE OF BIRTH Baltimore		16. DATE OF BIRTH 01/01/20	
17. SEX OF BIRTH Male		18. RACE OF BIRTH White	
19. OCCUPATION OF BIRTH Teacher		20. MARITAL STATUS OF BIRTH Married	
21. PLACE OF BIRTH Baltimore		22. DATE OF BIRTH 01/01/20	
23. SEX OF BIRTH Male		24. RACE OF BIRTH White	
25. OCCUPATION OF BIRTH Teacher		26. MARITAL STATUS OF BIRTH Married	
27. PLACE OF BIRTH Baltimore		28. DATE OF BIRTH 01/01/20	
29. SEX OF BIRTH Male		30. RACE OF BIRTH White	
31. OCCUPATION OF BIRTH Teacher		32. MARITAL STATUS OF BIRTH Married	
33. PLACE OF BIRTH Baltimore		34. DATE OF BIRTH 01/01/20	
35. SEX OF BIRTH Male		36. RACE OF BIRTH White	
37. OCCUPATION OF BIRTH Teacher		38. MARITAL STATUS OF BIRTH Married	
39. PLACE OF BIRTH Baltimore		40. DATE OF BIRTH 01/01/20	
41. SEX OF BIRTH Male		42. RACE OF BIRTH White	
43. OCCUPATION OF BIRTH Teacher		44. MARITAL STATUS OF BIRTH Married	
45. PLACE OF BIRTH Baltimore		46. DATE OF BIRTH 01/01/20	
47. SEX OF BIRTH Male		48. RACE OF BIRTH White	
49. OCCUPATION OF BIRTH Teacher		50. MARITAL STATUS OF BIRTH Married	
51. PLACE OF BIRTH Baltimore		52. DATE OF BIRTH 01/01/20	
53. SEX OF BIRTH Male		54. RACE OF BIRTH White	
55. OCCUPATION OF BIRTH Teacher		56. MARITAL STATUS OF BIRTH Married	
57. PLACE OF BIRTH Baltimore		58. DATE OF BIRTH 01/01/20	
59. SEX OF BIRTH Male		60. RACE OF BIRTH White	
61. OCCUPATION OF BIRTH Teacher		62. MARITAL STATUS OF BIRTH Married	
63. PLACE OF BIRTH Baltimore		64. DATE OF BIRTH 01/01/20	
65. SEX OF BIRTH Male		66. RACE OF BIRTH White	
67. OCCUPATION OF BIRTH Teacher		68. MARITAL STATUS OF BIRTH Married	
69. PLACE OF BIRTH Baltimore		70. DATE OF BIRTH 01/01/20	
71. SEX OF BIRTH Male		72. RACE OF BIRTH White	
73. OCCUPATION OF BIRTH Teacher		74. MARITAL STATUS OF BIRTH Married	
75. PLACE OF BIRTH Baltimore		76. DATE OF BIRTH 01/01/20	
77. SEX OF BIRTH Male		78. RACE OF BIRTH White	
79. OCCUPATION OF BIRTH Teacher		80. MARITAL STATUS OF BIRTH Married	
81. PLACE OF BIRTH Baltimore		82. DATE OF BIRTH 01/01/20	
83. SEX OF BIRTH Male		84. RACE OF BIRTH White	
85. OCCUPATION OF BIRTH Teacher		86. MARITAL STATUS OF BIRTH Married	
87. PLACE OF BIRTH Baltimore		88. DATE OF BIRTH 01/01/20	
89. SEX OF BIRTH Male		90. RACE OF BIRTH White	
91. OCCUPATION OF BIRTH Teacher		92. MARITAL STATUS OF BIRTH Married	
93. PLACE OF BIRTH Baltimore		94. DATE OF BIRTH 01/01/20	
95. SEX OF BIRTH Male		96. RACE OF BIRTH White	
97. OCCUPATION OF BIRTH Teacher		98. MARITAL STATUS OF BIRTH Married	
99. PLACE OF BIRTH Baltimore		100. DATE OF BIRTH 01/01/20	

1. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1987.

2. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1987.

3. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1987.

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10. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1987.

14072

CERTIFICATE OF DEATH

Reg. Dist. No. 13978

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>U.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Sanatorium</u>		d. STREET ADDRESS <u>39 Franklin St</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLOTTE STEELE</u> First Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 23^d 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years lost birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nevett Steele</u>		14. MOTHER'S MAIDEN NAME <u>Anna Brooke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		18. SOCIAL SECURITY NO. <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL SCLEROSIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 8</u> , 19 <u>59</u> , to <u>12-11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12-11</u> , 19 <u>60</u> , and that death occurred at <u>2:15</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry J. London</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 Norwood Dr.</u>	
PHYSICIAN'S NAME (Type) <u>Cherry Chase, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-14-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cent</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>DEC 15 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. After death. Page 4 of 4. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

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14019

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13979

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b Since 11/26/60 d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON SAN. & HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10,213 McKENNY AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEONARD Middle (NMI) Last AVERY		4. DATE OF DEATH Month DEC. Day 15 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 31, 1885
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman; Ivy-City Repair Shop-Union Station		10b. KIND OF BUSINESS OR INDUSTRY (Locomotive repairs)	
11. BIRTHPLACE (State or foreign country) WASHINGTON, DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE AVERY		14. MOTHER'S MAIDEN NAME MAY MORAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ELMER W. AVERY, 8328 QUENTIN ST., CARROLLTON, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 181.0 DUE TO carcinoma of bladder Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) carcinoma of bladder (c) carcinoma of bladder		INTERVAL BETWEEN ONSET AND DEATH 5 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/27/60 to 12/15/60 . 19. I saw the deceased alive on 12/14/60 , and that death occurred at A. M. from the causes and on the date stated above.			
22a. SIGNATURE Arthur J. Wilets		22b. DATE SIGNED 12/15/60	
22c. PHYSICIAN'S NAME (Type) Arthur J. Wilets, M. D.		22d. ADDRESS 1015 Spring St., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC. 19, 1960	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	23d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Ziska		25a. REC'D BY REGISTRAR DEC 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur J. Wilets			

STATE OF NEW YORK
DEPARTMENT OF HEALTH

1901

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14086
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 13980

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY 83X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 901 Hillwood Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Helen Middle E Last BAKER				4. DATE OF DEATH Month December Day 5 Year 19 60			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-4-97	
9. AGE (In years lost birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative		10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William CLARKSON				14. MOTHER'S MAIDEN NAME Victoria LANHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT (D) Mrs. Jane B. Brant, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe brain damage 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant brain tumor DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 30 19 60 to Dec. 5 19 60 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 5 19 60 , and that death occurred at 1:50AM M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Barclay W. Shepard</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-5-60	
22c. PHYSICIAN'S NAME (Type) Barclay W. SHEPARD, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-6-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Humphrey</i>				ADDRESS R. A. Humphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE DEC 7 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneub</i>			

1058

CERTIFICATE OF DEATH

1058

Virginia
Falls Church
5 days

901 Hillwood Ave.
U. S. Naval Hospital

December 2, 1950
12-11-50
X
Cause of Death
Helen
Administrative

U.S.A.
Washington, D. C.
U.S. Govt.
William Clarkson

No. (2) Mrs. Jane H. Grant, same as above

Severe brain damage
Malignant brain tumor

Nov. 10 1:50 PM
Dec. 2 1:50 PM
x

James W. Smith

Dr. J. W. Smith, Jr., U.S. Naval Hospital, Bethesda, Md.

Maryland
Baltimore
12-8-50
J. A. Murphy, Funeral Home, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
14021
MONTGOMERY
13981

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>17 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>503 Empress Ct.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>SMITH</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1980</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elias Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>147-05-3182</u>	
17. INFORMANT Address <u>Daughter (Mrs. Glend Berk) same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, papillary, left kidney</u> 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>with metastasis to bladder</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>April 16, 1957</u> to <u>December 20, 1960</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Dec 19</u> 19 <u>60</u> , and that death occurred at <u>12:35 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Aaron H. Traum</u>		22b. DATE SIGNED <u>Dec 21, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum, M. D.</u>		22d. ADDRESS <u>8237 Georgia Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		23b. DATE THEREOF <u>12/22/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN MAUSOLEUM</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 27 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Traut</u>			

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
14087
MONTGOMERY
12082
75X-2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Manheim	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle Alan Last Bashore		4. DATE OF DEATH Month December Day 3 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-57
9. AGE (In years lost birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph W. Bashore		14. MOTHER'S MAIDEN NAME Marion C. Mc Manus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ralph W. Bashore (Father)		Address 132 S. Main St. Manheim, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 754.5 (c) since birth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 November 60 , to 3 December 60 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 3 December 60 , and that death occurred at 8:30A , from the causes and on the date stated above.			
22a. SIGNATURE C. W. BRAMLETT, LT, MC, USN		22b. DATE SIGNED 3 December 1960	
22c. PHYSICIAN'S NAME (Type) C. W. BRAMLETT, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 12-4-60		23b. DATE THEREOF 12-4-60	
23c. NAME OF CEMETERY OR CREMATORY Memorial Gardens		23d. LOCATION (City, town, or county) (State) Charleston S.C.	
24. FUNERAL DIRECTOR'S SIGNATURE K. A. Rousley Funeral Home		25a. REC'D BY REGISTRAR DATE DEC 6 '60	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

14087

1. Name of deceased: David
2. Age: 30
3. Sex: Male
4. Race: White
5. Date of birth: 1940
6. Date of death: 1970
7. Place of death: U.S. Naval Hospital, Bethesda, Md.
8. Cause of death: ...
9. Signature of physician: ...
10. Signature of registrar: ...

U.S. Naval Hospital, Bethesda, Md.
11. Date of death: 1970
12. Signature of registrar: ...
13. Signature of physician: ...
14. Date of death: 1970

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Disl. No. **13983**

14088

Item 8 Film G278 1-3-61 et

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY montg		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp			d. STREET ADDRESS 1205 E Argyle Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle Francis Last Baumer			4. DATE OF DEATH Month 12 Day 21 Year 1960		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-56		9. AGE (In years last birthday) 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school		10b. KIND OF BUSINESS OR INDUSTRY md		11. BIRTHPLACE (State or foreign country) M.S.C.	
13. FATHER'S NAME Robert Baumer			14. MOTHER'S MAIDEN NAME Kathleen Smith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Kathleen Smith Baumer (mother)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral edema 812X DUE TO (b) Cerebral Contusions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Basal Skull Fracture					INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Report that he ran across st. in front of truck			
20c. TIME OF INJURY Month, Day, Year Hour 3:22 p.m. 12-21 1960		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	
		20f. (City or town) Rockville		20g. (County) montg	
		20h. (State) md			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Bhoschert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-22-60	
EXAMINER'S NAME (Type) FRANK J. BHOSCHERT		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn	
				22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		ADDRESS Funeral Home		24a. REC'D BY REGISTRAR DEC 27 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 97 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 5404 N. Carlyn Springs Rd.		g. DATE OF DEATH Month December Day 24 Year 19 60		h. DATE OF DEATH Month December Day 24 Year 19 60	
3. NAME OF DECEASED (Type or print) Robert Alden BEAVERS		4. DATE OF DEATH Month December Day 24 Year 19 60		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-30-28		9. AGE (In years last birthday) 32 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James BEAVERS		14. MOTHER'S MAIDEN NAME Marlyn TREAT / Marion Treat		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1948 to 1960		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Empyema, Organism unknown DUE TO S 87.0 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hepatic Abscesses DUE TO unknown (c) Pancreatitis DUE TO 1 year		INTERVAL BETWEEN ONSET AND DEATH unknown		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 18 19 60 to Dec. 24 19 60 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Dec. 24 19 60 , and that death occurred at 4P. M. from the causes and on the date stated above.	
22a. SIGNATURE V. N. HOUK, LCDR, MC, USN		22b. DATE SIGNED 12-25-60		22c. PHYSICIAN'S NAME (Type) U. S. Naval Hospital, Bethesda, Md.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. DATE SIGNED 12-25-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-30-60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town, or county) Washington, D. C.		23e. LOCATION (City, town, or county) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		24a. ADDRESS WashDC Chapin St., N.		25a. REC'D BY REGISTRAR WDEC 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. REGISTRAR'S SIGNATURE Arthur S. Kline	

U.S. DEPARTMENT OF HEALTH

1980

Virginia

Washington

Montgomery

Bartholomew (General)

St. Louis

Washington

James M. Cantlin Springs, VA.

J. S. Newel Hospital

X

60

24

December

DECEMBER

Alison

Robert

32

8-30-53

Constitution

Self

USA

California

V. S. Navy

Officer

James Newel

James Newel

Hospital Records

1950 to 1960

Yes

X

60

Dec. 24

60

Aug. 15

45

60

Dec. 24

X

12-2-53

U. S. Naval Hospital, Bethesda, Md.

V. S. Navy, 1950, USA

Washington, D. C.

V. S. Naval Observatory

12-30-53

Medical

W. V. Chambers, 1400 Chapin St., N. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14022

13985

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>34 Weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>2807 Randolph Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bennett</u> Middle <u>Bennett</u> Last <u>Bennett</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1960</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>39</u> Hours <u>25</u> Min. <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry John Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Elizabeth Harper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father - Same as Above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-20</u> 19 <u>60</u> to <u>12-22</u> 19 <u>60</u> that (I) (<u>we</u>) lost saw the deceased alive on <u>12-21</u> 19 <u>60</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Carolyn S. Pincock</u>		22b. DATE SIGNED <u>12-22-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>CAROLYN S. PINCOCK</u>		22d. ADDRESS <u>1944-Seminary Road S.S.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-23-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Redland Burial</u>		23d. LOCATION (City, town, or county) (State) <u>Redland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Syrus Wheeler - Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 27 '60</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

2075213XVI

CERTIFICATE OF DEATH

14055



[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]



14055

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13986

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. (D.C.) b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 5210 Wisconsin Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doris Middle L. Benoit Last				4. DATE OF DEATH Month 12 Day 26 Year 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-30-08	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rhode Island	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Thos. R. Ludgate				14. MOTHER'S MAIDEN NAME Gertrude Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Husband (Henry Benoit)		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mild diabetes mellitus + generalized arteriosclerosis							
INTERVAL BETWEEN ONSET AND DEATH 4 days 6 year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 12/11				20g. (County) 12/26		20h. (State) 1960	
21. I certify that (I) (this hospital) attended the deceased from 12/11 1960 to 12/26 1960 that (I) (we) last saw the deceased alive on 12/26 1960 , and that death occurred at 12/26 1960 , from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. O'Connor				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) THOMAS F. O'CONNOR				22d. ADDRESS 4861 BATTERY LANE BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S NAME (Type) ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14062

CERTIFICATE OF DEATH

13987

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		
c. LENGTH OF STAY IN 1b <u>15 yrs.</u>			d. STREET ADDRESS <u>6807 Conn. Avenue</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6807 Conn. Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Eligabeth Richardson Bessey</u>			4. DATE OF DEATH <u>Dec 5 1960</u>		
5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>June 19, 1896</u>		
9. AGE (In years last birthday) <u>64</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Kentucky</u>		
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Frank Richardson</u>			14. MOTHER'S MAIDEN NAME <u>Bernice Summers</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Daughter - Jean Browning</u>			Address <u>5409 Moreland Rd. Bethesda</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary vascular disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1960</u> to <u>Dec 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov. 25 1960</u> , and that death occurred on <u>9 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Marvin Wadler</u>					
22b. DATE SIGNED <u>12/5/60</u>					
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>					
22d. ADDRESS <u>8218 Wisconsin Av. BETH., MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/7/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>					
25a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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14065

CERTIFICATE OF DEATH

6907 Court Avenue

Sherry Jones

8006

Notary Public for the State of California

Notary Public for the State of California

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14091

CERTIFICATE OF DEATH

13988

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Washington, D.C.</i> b. COUNTY <i>47 X-3</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 yrs 6 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i>				d. STREET ADDRESS <i>3236 N St N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Eleanor</i> Middle <i>Birnie</i> Last <i>Birnie</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>25</i> Year <i>1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 5 1887</i>		9. AGE (In years last birthday) <i>73</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>TANEYTOWN MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Birnie</i>				14. MOTHER'S MAIDEN NAME <i>Zolliekopper</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Mr. C. Birnie Jr. 4328 Drvin Ave.</i>		Address <i>State College, Pa.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Transition and malnutrition</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arthritis of Hips and Spine, and</i> (c) <i>Generalized arteriosclerosis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>10 years</i> <i>20 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Partial intestinal obstruction</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 27, 1958</i> to <i>Dec 25, 1960</i> , that (I) lost saw the deceased alive on <i>Dec 8, 1960</i> and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>R. Stephen Hulbert</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>R. Stephen Hulbert, MD</i>				22d. ADDRESS <i>3000 Dent Place NW, Washington DC</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>12-28-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PINEY CREEK</i>		23d. LOCATION (City, town, or county) (State) <i>TANEYTOWN MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>				25a. REC'D BY REGISTRAR <i>2557 Wisconsin Ave</i> <i>BETHESDA MD</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

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Received of Mr. J. H. Smith
the sum of \$10.00
for the repair of a
Hats
July 2, 1912
J. H. Smith
14001

14001

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG277 12-21-60 et

Reg. Dist. No.

18989

FOR STATE
HEALTH DEPT.

14092

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle V Last Bowser		4. DATE OF DEATH Month December Day 12 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 19, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Sewing	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U/S	
13. FATHER'S NAME William Adams		14. MOTHER'S MAIDEN NAME Ann Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 191-10-5872	
17. INFORMANT Penna. Funeral Director-Philipsburg, Pa		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 13 hours DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 13 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschert		DATE SIGNED 12-12-60	
EXAMINER'S NAME (Type) FRANK J. Broschert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 12/15/60	22c. NAME OF CEMETERY OR CREMATORY Philipsburg Cemetery	22d. LOCATION (City, town, or county) (State) Centre Co. Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DEC 15 '60	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>345 University Blvd, West</u>		d. STREET ADDRESS <u>110204 Calumet Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Harold HOMER Bracken</u>		4. DATE OF DEATH <u>Dec 28 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/23</u>
9. AGE (In years lost birthday) <u>37</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - Amer. Psychological Ass'n.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOMER BRACKEN</u>		14. MOTHER'S MAIDEN NAME <u>unknown JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW # 2</u>		16. SOCIAL SECURITY NO. <u>193-14-6429</u>	
17. INFORMANT <u>Leona Bracken</u>		Address <u>10,204 Calumet Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Diabetes mellitus</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 26, 1958</u> , to <u>Dec 28, 1960</u> , that I lost s/he the deceased alive on <u>Dec 28, 1960</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond Bradshaw</u> , M.D.		ADDRESS (Street, city or town, state) <u>345 University Blvd, West</u> DATE SIGNED <u>12/28/60</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, Jr.</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. BUMPERS, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u> <u>4</u> '61		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14000

CERTIFICATE OF DEATH

14000

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Signature of informant: _____

11. Name of informant: _____

12. Address of informant: _____

13. Date of completion: _____

14. Registrar's office: _____

15. Registrar's name: _____

16. Registrar's address: _____

17. Registrar's telephone: _____

18. Registrar's fax: _____

19. Registrar's email: _____

20. Registrar's website: _____

21. Registrar's contact information: _____

22. Registrar's contact information: _____

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100. Registrar's contact information: _____

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14093

13991

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 6 mos. 14 das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 8500 Rosewood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle M Last Bradley				4. DATE OF DEATH Month 12 Day 12 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 5 - 1873	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 12 Days 12 Hours 19 Min.		IF UNDER 24 HRS. Months 12 Days 12 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hswf.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Mc Donald				14. MOTHER'S MAIDEN NAME Mary Benton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter (Mrs. Katherine Bell (Same as above))			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) 7 mos						INTERVAL BETWEEN ONSET AND DEATH 7 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-12-60 to Dec 12 , 19 60 , that (I) (we) last saw the deceased alive on Dec 12 , 19 60 , and that death occurred at 1:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE Wm. T. Joyce				22b. DATE SIGNED 12/12/60		22c. PHYSICIAN'S NAME (Type) Wm. T. Joyce	
22d. ADDRESS 8106 Maple Ridge Rd. Beth. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/60		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 20 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kneel			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Brochart notified

14094
MONTGOMERY
13992
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4869 Battery Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle C Last hiles Bradley		4. DATE OF DEATH Month Dec. Day 26 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1882
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME William O. Bradley	
14. MOTHER'S MAIDEN NAME Laura Moffatt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter (Mrs. Donald Deane) Address Same as Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 1 week DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right hip & Generalized Arteriosclerosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while walking on icy pavement	
20c. TIME OF INJURY Month, Day, Year 10 Hour 12 17 1960	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. City or town (County) (State) Bethesda Mont Md
21. I certify that (I) (this hospital) attended the deceased from Dec 17 1960, to Dec 26 1960, that (I) (we) last saw the deceased alive on Dec 25 1960, and that death occurred at 7:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Thomas O'Conner		22b. DATE SIGNED 12/26/60	
22c. PHYSICIAN'S NAME (Type) Thomas O'Conner		22d. ADDRESS 4861 BATTERY LANE, BETHESDA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/28/60	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City, town, or county) (State) Rockville, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE DATE DEC 29 '60		25c. REGISTRAR'S SIGNATURE Arthur L. Knave	

110004
CERTIFICATE OF DEATH
Name: [illegible]
Age: [illegible]
Sex: [illegible]
Race: [illegible]
Date of Birth: [illegible]
Date of Death: [illegible]
Place of Birth: [illegible]
Place of Death: [illegible]
Cause of Death: [illegible]
Manner of Death: [illegible]
Signature: [illegible]
Date: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14073

CERTIFICATE OF DEATH

Reg. Dist. No. 13993

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Kensington, Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3907 Hampden Street				d. STREET ADDRESS 13907 Hampden Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mae Middle Florence Last Briscoe				4. DATE OF DEATH Month December Day 11 Year 609			
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 22 1894	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel P. Jackson				14. MOTHER'S MAIDEN NAME Bell Doye			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Address Glenwood Bailey - Silver Spring, Route # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary Arteriosclerosis DUE TO (c) Hypertensive Cardioresenal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gallbladder Trouble						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/8/37 , 19___, to 12/11/60 , 19___, that I last saw the deceased alive on 12/11/60 , 19___, and that death occurred at 4:53 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck DATE SIGNED 12/16/60							
ACTUAL SIGNATURE Webster Sewell M.D.				DATE SIGNED 12/16/60			
PHYSICIAN'S NAME (Type) Webster Sewell				ADDRESS Rt. 1 Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/60		22c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery		22d. LOCATION (City, town, or county) (State) Clarksville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				24a. REC'D BY REGISTRAR DATE DEC 22 '60		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1928

CERTIFICATE OF DEATH

14073

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14095

CERTIFICATE OF DEATH

Reg. Dist. No.

13994

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Donora	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 538 Castner Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle (None) Last Brizzi				4. DATE OF DEATH Month December Day 8 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1953	
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.		IF UNDER 24 HRS. Months 7 Days 7 Hours 7 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME James V. Brizzi				14. MOTHER'S MAIDEN NAME Marie Luzzi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphocarcinoma DUE TO 200.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 200.1 DUE TO (c) 200.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 200.1 INTERVAL BETWEEN ONSET AND DEATH 1 mo							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 30 , 19 60 , to December 8 , 19 60 , that I last saw the deceased alive on December 8 , 19 60 , and that death occurred at 11:23P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/9/60 ACTUAL SIGNATURE Edward E. Morse M.D. The Clinical Center NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland PHYSICIAN'S NAME (Type) Edward E. Morse M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 12/12/60							
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Sem.							
22d. LOCATION (City, town, or county) (State) Monogahela, Penna.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland							
24a. REC'D BY REGISTRAR DATE DEC 15 '60							
24b. REGISTRAR'S SIGNATURE William S. K...							

14001

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 36	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA NURSING HOME		d. STREET ADDRESS 11504 REGNID DRIVE 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BETTY		4. DATE OF DEATH DECEMBER 16 1960	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 18, 1870	
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) RIGA, LATVIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB WOFSY		14. MOTHER'S MAIDEN NAME RACHEL KAPLAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address MRS. ISRAEL ROTKIN 11504 REGNID DRIVE. SS, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) general arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs Indef Indef	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia & Heart Failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/2 , 19 55 , to 12/16 , 19 60 that I last saw the deceased alive on 12/16 , 19 60 , and that death occurred at 2:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen L. Jones		ADDRESS (Street, city or town, state) Rockville, Md DATE SIGNED 12/16/60	
PHYSICIAN'S NAME (Type) STEPHEN L. JONES, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-18-60	
22c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEM.		22d. LOCATION (City, town, or county) (State) LONG ISLAND - N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS - 3501-14757 NW		24a. REC'D BY REGISTRAR DEC 19 1960	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

14001

INVESTIGATION OF DEATH

Page 1 of 1

DEPARTMENT OF HEALTH

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14096
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

13996

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 5 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4000 Cathedral			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ernest Middle William Last BROWN		4. DATE OF DEATH Month December Day 23 Year 1960		5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-14-78		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 47 Days 23 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Harris BROWN				14. MOTHER'S MAIDEN NAME Mary Cornelia DOWLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1903-1942		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterioscleortic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 min years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture, left hip						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 1960 Dec. 23 9:32AM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from Dec. 18 1960 to Dec. 23 1960 , that (he) (we) last saw the deceased alive on Dec. 23 1960 , and that death occurred at 9:32AM , from the causes and on the date stated above.							
22a. SIGNATURE <i>M. C. Wilber</i>				22b. DATE SIGNED 12-23-60		22c. PHYSICIAN'S NAME (Type) M. C. WILBER, LCDR, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22e. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-24-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph S. Gowers</i>				25a. REC'D BY REGISTRAR DEC 29 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

CERTIFICATE OF DEATH

1948

State of Columbia

Maritime

Washington 15

2 days

Barbados (Island)

4000 Cathedral

U. S. Naval Hospital

BROWN

William

Spencer

December 21

US

1-14-75

M

Consolation

Male

USA

Connecticut

U. S. Navy

Medical Officer

Navy Cemetery, Hawaii

William Harris Brown

Hospital Records

1903-1945

Yes

House apocryphal reference

Attended by house physician

Prescribed, left his

Dec. 23

Dec. 23

Dec. 19

Dec. 23

Dec. 23

Dec. 23

Dec. 23

x

U. S. Naval Hospital, Barbados, B.I.

M. C. Wilson, MD, USN

1948

Barbados

Cecil Hills Cemetery

19-24-50

Interment

Witness

John, Captain's home funeral home, 1150 P.O. Ave., in

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13997

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4608 Langdrum Lane				d. STREET ADDRESS 4608 Langdrum Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Fredrick W Browne				4. DATE OF DEATH Month Day Year December 16 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1875		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 1 Days 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brig. Gen.-ret.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William L. Browne				14. MOTHER'S MAIDEN NAME Mary Meclure			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-40-9610		17. INFORMANT Address William L. Browne-son-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/60		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR DEC 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED Mary Ann		SEX Female		AGE 40		RACE White	
PLACE OF BIRTH New York		DATE OF BIRTH 1880		PLACE OF DEATH New York		DATE OF DEATH 1920	
OCCUPATION None		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		MEDICAL OPINION None	
SIGNATURE OF EXAMINER J. J. [Signature]		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS J. J. [Signature]		SIGNATURE OF [Other]	
ADDRESS OF EXAMINER 123 [Address]		ADDRESS OF DECEASED 456 [Address]		ADDRESS OF WITNESS 789 [Address]		ADDRESS OF [Other]	
CITY New York		COUNTY New York		STATE New York		ZIP CODE 10000	
DATE OF EXAMINATION 1920		TIME OF EXAMINATION 10:00 AM		PLACE OF EXAMINATION Home		NAME OF PHYSICIAN J. J. [Signature]	
SIGNATURE OF PHYSICIAN J. J. [Signature]		SIGNATURE OF EXAMINER J. J. [Signature]		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS J. J. [Signature]	
ADDRESS OF PHYSICIAN 123 [Address]		ADDRESS OF EXAMINER 123 [Address]		ADDRESS OF DECEASED 456 [Address]		ADDRESS OF WITNESS 789 [Address]	
CITY New York		COUNTY New York		STATE New York		ZIP CODE 10000	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14020
CERTIFICATE OF DEATH

13998

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sav. & Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Peggy Lee Bulard</i>		4. DATE OF DEATH <i>12 26 19 60</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/27/91</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>James Earl Faircloth</i>		14. MOTHER'S MAIDEN NAME <i>MIMIE unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Sp't Hospital record.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage & shock</i> DUE TO <i>arterial degeneration</i> (b) <i>Arteriosclerosis plus arterial wall changes</i> (c) <i>Modular growth</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Modular growth</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 day</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12/26/1960</i> to <i>12/26/1960</i> , that (I) (we) last saw the deceased alive on <i>12/26/1960</i> and that death occurred at <i>12/26/1960</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas H. Wolohan, M.D.</i>		22b. DATE SIGNED <i>12/26/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Thomas H. Wolohan</i>		22d. ADDRESS <i>7401 Blair Rd NW</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12/28/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>BULLARD FAMILY BURYING GROUNDS, NEAR ROSEBORO, CUMBERLAND CO.,</i>		23d. LOCATION (City, town, or county) (State) <i>N.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Jiska</i>		25a. REC'D BY REGISTRAR <i>DEC 29 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

14020

CERTIFICATE OF DEATH

NAVY AND ARMY DEPARTMENT
BUREAU OF MEDICAL SERVICE
WASHINGTON, D. C.

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to contain details of a death certificate, including names, dates, and medical information.]

14097

CERTIFICATE OF DEATH

Reg. Dist. No. 13999

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8716 EWING DRIVE				d. STREET ADDRESS 1 8716 EWING DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ISADOR Middle BURDETT Last BURDETT				4. DATE OF DEATH Month DECEMBER Day 27 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 22, 1898		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MEDEL BURDETT				14. MOTHER'S MAIDEN NAME RACHEL LEVIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MELVIN BURDETT		Address 4201 MASSACHUSETTS AVE., N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinomatosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) adenocarcinoma large bowel							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 19 60 , to Dec. 27, 1960 , that I last saw the deceased alive on Dec. 27, 1960 , and that death occurred at 6:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D.				ADDRESS (Street, city or town, state) 4890 Battery Lane, Bethesda			
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut M.D.				DATE SIGNED 12/27/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-29-60		22c. NAME OF CEMETERY OR CREMATORY OHEV SHOLOM-TALMUD TORAH CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS				ADDRESS 3501 14th Street, N.W.		24a. REC'D BY REGISTRAR DATE DEC 30 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

B. DAVIS 15-52-00 OHIA		14007 CERTIFICATE OF DEATH MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18	
NAME OF DECEASED JOHN J. DAVIS		SEX MALE	
DATE OF DEATH JANUARY 15, 1900		PLACE OF DEATH BALTIMORE, MARYLAND	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE, MARYLAND		AGE 45 YEARS	
OCCUPATION LABORER		MARITAL STATUS SINGLE	
EDUCATION HIGH SCHOOL		RELIGION ROMAN CATHOLIC	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF JURY (None)		SIGNATURE OF JUDGE (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)	

14098

DO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 40 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 434 Ethan Allen Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Herbert		Middle Bradley		Last BURGER	
4. DATE OF DEATH		Month December		Day 24		Year 1960	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-08	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52		IF UNDER 24 HRS. Days 52		Hours 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert B. BURGER				14. MOTHER'S MAIDEN NAME Hattie Ball			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1933-54		17. INFORMANT Takoma Park, Md. Hattie Ball BURGER 434 Ethan Allen Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Carcinomatosis, generalized, primary PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) undetermined DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) undetermined DUE TO (c) undetermined INTERVAL BETWEEN ONSET AND DEATH 9 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 14 11:00 AM to Dec 24 , 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 24 Dec , 19 60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE C. W. Bramlett, Lt., MC, USN				22b. DATE SIGNED 12-25-60		22c. PHYSICIAN'S NAME (Type) XXXXXXXXXXXXXXXXXXXX	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22e. REC'D BY REGISTRAR DATE DEC 29 '60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-28-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Takoma Funeral Home				25. ADDRESS 254 Carroll Ave, D.C.		25b. REGISTRAR'S SIGNATURE C. W. Bramlett	

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF DECEASED

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF WITNESS

DATE OF WITNESSING

PLACE OF WITNESSING

NAME OF SIGNER

DATE OF SIGNING

PLACE OF SIGNING

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14001

14099

Item 3 File 6277 12-23-60 at

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 20 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter Stanley Burroughs		4. DATE OF DEATH Dec. 20 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/16/20	
9. AGE (In years lost birthday) 40 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter M. Burroughs		14. MOTHER'S MAIDEN NAME Matie Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 216-01-6148	
17. INFORMANT Wife (Alfreda Burroughs)		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhages DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhagic diathesis DUE TO (c) Acute granulocytic leukemia		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 24, 1960 to Dec. 20, 1960 , that (I) (we) last saw the deceased alive on Dec. 19, 1960 , and that death occurred at 7 a M, from the causes and on the date stated above.			
22a. SIGNATURE Edward L. McGarry		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Edward McGarry, M.D.		22d. ADDRESS Suburban Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-22-60	
23c. NAME OF CEMETERY OR CREMATORY Brookeville		23d. LOCATION (City, town, or county) (State) Brookeville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Barber		25a. REC'D BY REGISTRAR DEC 23 '60	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

11000

Blank certificate form with faint lines and text for recording death information.

CERTIFICATE OF DEATH

Reg. Dist. No.

14002

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>12/10/60</u>		d. STREET ADDRESS <u>1232-Farragut Pl. N.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marble Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>O.</u> Last <u>BUTLER</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Butcher Meats</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meats</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles H. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret M. Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>577-07-6989</u>	
17. INFORMANT <u>Virginia M. Butler, wife</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>10-15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>JAN 1955</u> , to <u>Dec 13, 1960</u> , that I last saw the deceased alive on <u>DEC 10, 1960</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Grey</u>		ADDRESS (Street, city or town, state) <u>7105 Riggs Rd. Hyattsville Md.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT B. GREY</u>		DATE SIGNED <u>DEC 13 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Smithland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>DEC 13 1960</u>	
ADDRESS <u>Mt. Rainier Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1005 MERRIMAC DRIVE APT. #1					d. STREET ADDRESS 1005 MERRIMAC DRIVE APT. #1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PETER Middle (NMI) Last (PANOS) CAMBAS					4. DATE OF DEATH Month DEC. Day 15 Year 1960				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 1, 1886		9. AGE (In years last birthday) yrs. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CANDY MAKER, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY CANDY MANUFACTURING		11. BIRTHPLACE (State or foreign country) SMYRNA, TURKEY			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME DIMITRIOS CAMBAS					14. MOTHER'S MAIDEN NAME FOTINI POLITIS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] NO					16. SOCIAL SECURITY NO. 066-09-3345		17. INFORMANT IDA G. CAMBAS, 1005 MERRIMAC DRIVE, SILVER SPRG.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac decompensation 4 34 24 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic cardiac decompensation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 wks								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from September 1960 to December 15, 1960 , that (I) (we) last saw the deceased alive on December 12, 1960 , and that death occurred at 12:15 PM , from the causes and on the date stated above.									
22a. SIGNATURE Bennet A. Porter, Jr., M.D.					22b. DATE SIGNED December 16, 1960		22c. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.		
22d. ADDRESS 4301 Colesville Rd., Silver Spring, Md.					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF DEC. 19, 1960		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska					25a. REC'D BY REGISTRAR DATE DEC 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

14100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14004

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie R Carter</u>				4. DATE OF DEATH Month Day Year <u>12/29/60</u> 19 <u>60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8, 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ill.</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>N. Robertson</u>			
14. MOTHER'S MAIDEN NAME <u>Rogers</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>same</u> <u>Clarence E. Carter, husband</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Vascular Disease</u> DUE TO (c) <u>Digitalis Intoxication</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 27, 1960</u> to <u>Dec. 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 29, 1960</u> , and that death occurred at <u>9:20</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Gene U. Cohen</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec 29, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gene U. Cohen</u>				22d. ADDRESS <u>931 Pershing Dr., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 3 61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

14108

Jan 8, 1988

None

Cardinal, Va. state, 1988

1 and 1, 1988

Part 1, 1/2 of

Part 1, 1/2 of

Robert A. Thompson, Bethesda, Maryland

Robert A. Thompson, Bethesda, Maryland

1
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14023
MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14005

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince Geo</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BILLY</i> Middle <i>EDWARD</i> Last <i>CAVIN</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>9</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 7, 1960</i>
9. AGE (In years last birthday) <i>—</i> yrs.		10. IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i>	11. IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Takoma Park, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Billy Joe Cavin</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Jane Mays</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Herbert M. Cavin</i>		Address <i>6615 Westminster (TPR)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO <i>776X</i> (b) DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 8</i> 19 <i>60</i> , to <i>Dec 9</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>Dec</i> 19 <i>60</i> , and that death occurred at <i>P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Herbert J. Jacobs</i>		22b. DATE SIGNED <i>12/10/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Herbert J. Jacobs</i>		22d. ADDRESS <i>10620 Georgia Ave. Silver Spring MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 12, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>North York Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>North York Tenn.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Wallace</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	
ADDRESS <i>254 Carroll St NW. DC</i>		DATE <i>DEC 13 '60</i>	

Nov 20 75 161 XV V

CERTIFICATE OF DEATH

14024

Deceased

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14006

14101

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Hampton c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Mitchell Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Karen Gail CHAPMAN				4. DATE OF DEATH Month Day Year December 26 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-10-60	
9. AGE (In years lost birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 16		IF UNDER 24 HRS. Hours 16 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Stanley R. CHAPMAN				14. MOTHER'S MAIDEN NAME Ruby G. STRICKLAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, organism unknown DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Urinary tract infection, organism unknown DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 8 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital heart disease & convulsive disorder							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from Dec. 3 1960 to Dec. 26 1960 , that (I) was last saw the deceased alive on Dec. 26 1960 , and that death occurred at 12:50AM M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Lawrence G. Thorne</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-26-60	
22c. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 12-27-60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Norfolk Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>				ADDRESS Lee Funeral Home, 4th & Mass. Aves., NW, WashDC		25a. REC'D BY REGISTRAR DATE DEC 29 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thorne</i>			

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1

Nov

100 Potomac River, 4th & Mass. Aves., NW, Washing

12-21-50 - 12-21-50 - 12-21-50 - 12-21-50 - 12-21-50 - 12-21-50 - 12-21-50 - 12-21-50 - 12-21-50 - 12-21-50

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Congenital heart disease & convulsive disorder

Urinary tract infection, organism unknown

Septicemia, organism unknown

None Hospital records

Barney R. CHAPMAN Ruby G. STICKLAND

Female - - - - - Virginia USA

Chapman 8-10-50

Karen 8-11

U. S. Naval Hospital 13 November 50

Bedstead (R.L.) 21 days

Montgomery Virginia

1-101

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14024 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14007

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 715 Kennebec Ave.				d. STREET ADDRESS 715 Kennebec Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle H. Last CHAPPELL				4. DATE OF DEATH Month Dec. Day 25, Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 5, 1897		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rehabilitation Spec.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles M. Chappell				14. MOTHER'S MAIDEN NAME Leda Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Son Paul H. Chappell		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				24a. REC'D BY REGISTRAR DEC 29 '60 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14064

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14008

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4605 DRUMMOND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle FAULDS Last CHRISTOPHER		4. DATE OF DEATH Month DEC. 22 Day Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 15, 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) LIVERPOOL, ENGLAND		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
13. FATHER'S NAME THOMAS FAULDS		14. MOTHER'S MAIDEN NAME ALICE McCOMESKEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----	
17. INFORMANT MARY C. LETHBRIDGE, SAME AS # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-0 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Racine (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1960, to Dec. 22, 1960, that (I) (we) last saw the deceased alive on Dec. 22, 1960, and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas L. Hartman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) THOMAS L. HARTMAN		22d. ADDRESS 1834 Edgeview	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/26/60	
23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		23d. LOCATION (City, town, or county) RACINE, WISCONSIN (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Paulino		25a. REC'D BY REGISTRAR ADDRESS PA. AVE., N.W. DC (6)	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris		25c. DATE DEC 27 '60	

14004

CERTIFICATE OF DEATH

APPLICANT FOR THE DEATH CERTIFICATE
NAME OF DECEASED: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

Y

Y

10

Y

Y

11

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14025

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14009

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>✓ 47X-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>53 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District of Columbia</i>		d. STREET ADDRESS <i>1763 Columbia Rd. N.W.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lucienne</i> Middle <i>Margaret</i> Last <i>Clarke</i>		4. DATE OF DEATH Month <i>12</i> Day <i>9</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 24, 1911</i>
9. AGE (In years last birthday) <i>49</i> yrs.		10. IF UNDER 1 YEAR Months <i>12</i> Days <i>9</i> Hours <i>0</i> Min.	11. IF UNDER 24 HRS. Months <i>12</i> Days <i>9</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher - Dance school</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Europe</i>	
11. BIRTHPLACE (State or foreign country) <i>Europe</i>		12. CITIZEN OF WHAT COUNTRY? <i>America - USA</i>	
13. FATHER'S NAME <i>Lucian Bernhard</i>		14. MOTHER'S MAIDEN NAME <i>Margaret F. von R. Heinemann</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>Washington San & Hosp. Records</i>	
17. INFORMANT <i>Washington San & Hosp. Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>193.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chorea, left Temporo-parietal</i> DUE TO (c) <i>12 mos.</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 10, 1960</i> to <i>Dec 9, 1960</i> that (I) (we) last saw the deceased alive on <i>Dec 9, 1960</i> , and that death occurred at <i>12 M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>John T. Lord</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>John T. Lord</i>		22d. ADDRESS <i>1015 Spring St. Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Dec 10, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Prince Geo. County Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walker</i>		25a. REC'D BY REGISTRAR <i>DEC 13 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur Walker</i>		25c. DATE <i>DEC 13 '60</i>	

14027

CERTIFICATE OF DEATH



14080

CERTIFICATE OF DEATH

Reg. Dist. No.

14010

1. PLACE OF DEATH a. COUNTY M MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 Blandford St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NOAH Middle EDWARD Last CLEM				4. DATE OF DEATH Month DEC. Day 10 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/02	
9. AGE (In years lost birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ADDISON ELMORE CLEM				14. MOTHER'S MAIDEN NAME ANNA ELIZ. LLOYD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. WIFE (SAME AS ABOVE)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subendocardial Myocardial Infarction 420-1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis (c) Coronary atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH Acute Acute Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/1/1960 to 12/10/1960 , that I last saw the deceased alive on 12/10/1960 , and that death occurred at 5:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 803 Viers Mill Road, Rockville, Md. DATE SIGNED 12/10/60							
ACTUAL SIGNATURE Stephen N. Jones				M.D. 12/10/60			
PHYSICIAN'S NAME (Type) STEPHEN N JONES				803 Viers Mill Road, Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12/13/60		Jacksonville		Floyd, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home 1331 E. Montgomery Ave., Rockville, Md.				24a. REC'D BY REGISTRAR DATE DEC 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krawe	

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-10-80

RECEIVED
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH AND SAFETY
WASHINGTON, D.C. 20461

1-10-80

TO: DIRECTOR, FEDERAL BUREAU OF INVESTIGATION
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

14102

CERTIFICATE OF DEATH

14011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 64 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 1363 Peabody Street, N.W. Apt. 204		
3. NAME OF DECEASED (Type or print) First Louis Middle (None) Last Cohn			4. DATE OF DEATH Month December Day 4 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1895		9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (State or foreign country) Nebraska	
13. FATHER'S NAME Morris Cohn			14. MOTHER'S MAIDEN NAME Bluma (Unknown) Hilda		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 347-07-9134		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Clostridium Septicemia 572.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Regional Enteritis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Unknown 15 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arteriosclerosis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 1960 , to December 4, 1960 , that I last saw the deceased alive on December 4, 1960 , and that death occurred at 5:41 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Orlando W. McBride			ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 12-5-60
PHYSICIAN'S NAME (Type) ORLANDO W. McBRIDE, M.D.			National Institutes of Health Bethesda 14, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	
				22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-14th - NW			24a. REC'D BY REGISTRAR DATE DEC 9 '60		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

14012

14103

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Augusta			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson				c. LENGTH OF STAY IN lb 2 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 309 Betsybell			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Ida Middle C. Last Cook		4. DATE OF DEATH		Month 12 Day 17 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11 1876		9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Isaac Nicewander				14. MOTHER'S MAIDEN NAME Barbara Frank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Mrs. Nellie Wiseman		Address Dickerson Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) 3 yrs INTERVAL BETWEEN ONSET AND DEATH 8 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 2 , 19 60 , to Dec 17 , 19 60 that I last saw the deceased alive on Dec 16 , 19 60 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Vernon E. Hartens		M.D. German Town, Md.		DATE SIGNED Dec. 17, 60		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/60		22c. NAME OF CEMETERY OR CREMATORY Thornrose		22d. LOCATION (City, town, or county) (State) Staunton Va.	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Baltimore, Md.				24a. REC'D BY REGISTRAR DATE DEC 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14004

CERTIFICATE OF DEATH

14013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b Marilea Rest Home d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Rest Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6007 43 rd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHRISTAINA ROBB CROMAR		4. DATE OF DEATH Month 20 Day 25 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 2, 1867
9. AGE (In years lost birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Robb		14. MOTHER'S MAIDEN NAME Ann Spence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. non.	
17. INFORMANT Mrs Marian C. Herr- Daughter- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 42 201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) None			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-20, 1960 to 12-25, 1960 that I last saw the deceased alive on 1960 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John Rogers M.D. 1919 Severn Rd 12-25-60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) John Rogers MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

1800

CERTIFICATE OF DEATH

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Item 21 Film 6276 1-5-61 et 14104 14014 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>South Carolina</u> b. COUNTY <u>Conway</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u></p>				<p>c. LENGTH OF STAY IN 1b <u>40 days</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u></p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>William</u> Middle <u>Earl</u> Last <u>Crowgey</u></p>				<p>4. DATE OF DEATH</p> <p>Month <u>December</u> Day <u>29</u> Year <u>19 60</u></p>			
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>June 22, 1949</u></p>	
<p>9. AGE (In years last birthday) <u>11</u> yrs.</p>		<p>IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Virginia</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>				<p>13. FATHER'S NAME <u>William P. Crowgey</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>Betty Lindamood</u></p>				<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)</p>			
<p>16. SOCIAL SECURITY NO. <u>None</u></p>				<p>17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u></p> <p>204.3 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hyperuricemia</u></p> <p>DUE TO (c) <u>Acute Lymphatic Leukemia</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>						<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>4 days</u></p> <p><u>1 Week</u></p> <p><u>2 Months</u></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>						<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour o. m. p. m. <u>19</u></p>		<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I attended the deceased from <u>November 19, 19 60</u>, to <u>December 29, 19 60</u>, that I last saw the deceased alive on <u>December 29, 19 60</u>, and that death occurred at <u>7:00 AM</u>, from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12-29-60</u></p> <p>ACTUAL SIGNATURE <u>W. Walter Oppelt</u> M.D. <u>National Institutes of Health</u></p> <p>PHYSICIAN'S NAME (Type) <u>W. WALTER OPPELT, M.D.</u> <u>Bethesda 14, Maryland</u></p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><u>Burial-transit 12-29-60</u></p>		<p>22b. DATE THEREOF <u>12-29-60</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Conway, South Carolina</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE</p> <p><u>ROBERT A. PUMPHREY</u></p>				<p>ADDRESS <u>Bethesda, Md.</u></p>		<p>24a. REC'D BY REGISTRAR <u>JAN 3 '61</u></p>	
<p>24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u></p>				<p>24c. REGISTRAR'S SIGNATURE</p>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14101

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Nature of disease		8. Duration of illness	
9. Name of physician		10. Name of attending physician		11. Name of hospital		12. Name of funeral home	
13. Name of informant		14. Name of registrar		15. Name of registrar		16. Name of registrar	
17. Name of registrar		18. Name of registrar		19. Name of registrar		20. Name of registrar	
21. Name of registrar		22. Name of registrar		23. Name of registrar		24. Name of registrar	
25. Name of registrar		26. Name of registrar		27. Name of registrar		28. Name of registrar	
29. Name of registrar		30. Name of registrar		31. Name of registrar		32. Name of registrar	
33. Name of registrar		34. Name of registrar		35. Name of registrar		36. Name of registrar	
37. Name of registrar		38. Name of registrar		39. Name of registrar		40. Name of registrar	
41. Name of registrar		42. Name of registrar		43. Name of registrar		44. Name of registrar	
45. Name of registrar		46. Name of registrar		47. Name of registrar		48. Name of registrar	
49. Name of registrar		50. Name of registrar		51. Name of registrar		52. Name of registrar	
53. Name of registrar		54. Name of registrar		55. Name of registrar		56. Name of registrar	
57. Name of registrar		58. Name of registrar		59. Name of registrar		60. Name of registrar	
61. Name of registrar		62. Name of registrar		63. Name of registrar		64. Name of registrar	
65. Name of registrar		66. Name of registrar		67. Name of registrar		68. Name of registrar	
69. Name of registrar		70. Name of registrar		71. Name of registrar		72. Name of registrar	
73. Name of registrar		74. Name of registrar		75. Name of registrar		76. Name of registrar	
77. Name of registrar		78. Name of registrar		79. Name of registrar		80. Name of registrar	
81. Name of registrar		82. Name of registrar		83. Name of registrar		84. Name of registrar	
85. Name of registrar		86. Name of registrar		87. Name of registrar		88. Name of registrar	
89. Name of registrar		90. Name of registrar		91. Name of registrar		92. Name of registrar	
93. Name of registrar		94. Name of registrar		95. Name of registrar		96. Name of registrar	
97. Name of registrar		98. Name of registrar		99. Name of registrar		100. Name of registrar	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY MONTGOMERY					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2626 CORY TERRACE					d. STREET ADDRESS 2626 CORY TERRACE					
3. NAME OF DECEASED (Type or print) First Middle Last MARJORIE ANN CUNNINGHAM					4. DATE OF DEATH Month Day Year DEC. 11 1960					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 26, 1960		9. AGE (in years last birthday) yrs. 2 Months 15 Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE					10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM J. CUNNINGHAM					14. MOTHER'S MAIDEN NAME MARY VIRGINIA EUBANKS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO					16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Wm. J. Cunningham, 2626 Cory Terrace			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 475X Asphyxia DUE TO (b) Upper Respiratory Infection DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH Several hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCART					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-12-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/13/60		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or country) (State) MONTGOMERY COUNTY, MD.				
23. FUNERAL DIRECTOR WALTER E. PUMPHREY, INC. Raymond A. Baska					ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE DEC 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL EXAMINER CERTIFICATE OF DEATH

14005

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

12

12

DATE OF EXAMINATION

TIME OF EXAMINATION

1

NAME OF DECEASED

RESIDENCE

SIGNATURE OF EXAMINER

DATE OF SIGNATURE

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14016

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>mntg</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Building #30 Nat. I. Health</i>			d. STREET ADDRESS <i>110225- Douglas Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>William Edward Cunningham</i>	First	Middle	Lost	4. DATE OF DEATH Month <i>Dec</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-22-05</i>	9. AGE (in years last birthday) <i>55</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chummer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>DC</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Charles Cunningham</i>			14. MOTHER'S MAIDEN NAME <i>Ella Barry</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>578-07-3700</i>		17. INFORMANT <i>Mrs Elaine Cunningham (wife)</i> Address <i>Stn 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Collapsed while working on a construction job</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschant</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>12-13-60</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-16-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i>	22d. LOCATION (City, town, or county) <i>Washington</i>	(State) <i>Alto.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>		ADDRESS <i>3821-14th St. N. W., Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 19 '60</i>	24b. REGISTRAR'S SIGNATURE <i>William S. Hines</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14100
MASSACHUSETTS DEPARTMENT OF HEALTH-BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH: 1-15-1910
PLACE OF DEATH: At home
AGE: 65 SEX: M
OCCUPATION: Farmer
CAUSE OF DEATH: Heart failure
DISEASE: Myocarditis
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: Wm. J. Sullivan
DATE: 1-15-1910

1. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

2. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

3. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

4. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

5. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

6. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

7. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

8. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

9. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

10. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14106

14017

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle (None) B. Last Curran		4. DATE OF DEATH Month December Day 16 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Baker		14. MOTHER'S MAIDEN NAME Eulalia Alling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record, The Clinical Center		Address Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis / Heart Disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 5, 19 60 to December 16, 19 60 that (I) (we) last saw the deceased alive on December 16, 19 60 , and that death occurred at 1:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Thomas E. Gaffney		22b. DATE SIGNED 12/17/60	
22c. PHYSICIAN'S NAME (Type) Thomas E. Gaffney M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1960	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		25a. REC'D BY REGISTRAR DEC 21 '60	
ADDRESS 254 Carroll St NW DC		25b. REGISTRAR'S SIGNATURE Charles L. Kneave	

CERTIFICATE OF DEATH

14106

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14026

CERTIFICATE OF DEATH

14018

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10205 Southmoor Dr.</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Wanda Marie Dahowski</u>		4. DATE OF DEATH <u>Dec. 20 1960</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-13-12</u>		9. AGE (In years last birthday) <u>48 yrs.</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>Richard O'Donoghue</u>						14. MOTHER'S MAIDEN NAME <u>Mary Blanche MacWilliams</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>none</u>						16. SOCIAL SECURITY NO. <u>none</u>						17. INFORMANT <u>U.S. Hosp. Records -</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident - Hemorrhage</u> <u>33 IX</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>Unknown</u>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>									
21. I certify that (I) (this hospital) attended the deceased from <u>12-20</u> , 19 <u>60</u> , to <u>12-20</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12-20</u> , 19 <u>60</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>Stuart L. Nelson</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>12-20-60</u>							
22c. PHYSICIAN'S NAME (Type) <u>STUART L. NELSON</u>						22d. ADDRESS <u>Wash. San. & Hospital, Takoma Park, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>12/23/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>				23d. LOCATION (City, town or county) <u>MONTGOMERY COUNTY, MARYLAND</u> (State) <u> </u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zioka</u> ADDRESS <u>SILVER SPRING, MD.</u>						25a. REC'D BY REGISTRAR <u>DEC 27 '60</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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14020

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14019

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 1670-2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY College Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Reta May Dalziel		4. DATE OF DEATH Month December Day 2 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	11. BIRTHPLACE (State or foreign country) U.S.A.
13. FATHER'S NAME William Atkinson		14. MOTHER'S MAIDEN NAME Millie Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral vascular accident - hemorrhagic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized hypertensive cardiovascular DUE TO (c) 10 days 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Sept 19 60 to 2 Dec 19 60 , that (I) (we) last saw the deceased alive on 2 Dec 19 60 and that death occurred at 9:15 A M, from the causes and on the date stated above.			
22a. SIGNATURE Ernest F. Harmon		22b. ADDRESS 9301 Colesville Rd S.W. Spr. Md.	
22c. PHYSICIAN'S NAME (Type) Ernest F. Harmon M.D.		22d. ADDRESS 9301 Colesville Rd S.W. Spr. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12/5/60	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		25a. REC'D BY REGISTRAR DEC 5 '60	
25b. REGISTRAR'S SIGNATURE Carlton J. Hines		25c. DATE DEC 5 '60	

1111

CENTRAL OFFICE OF DEAN

14027

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[Faint, mostly illegible text covering the majority of the page, appearing to be a form or document with multiple lines of text.]

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

14006
MONTGOMERY
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14020
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 735 Sligo Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sadie First Dangiger Middle Dangiger Last		4. DATE OF DEATH December 11 Month 11 Day 1960 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/06
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR 2 Months 6 Dpys 6 Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Seif		14. MOTHER'S MAIDEN NAME Sarah Frank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-48-0875	
17. INFORMANT Henry Armin Dangiger Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition & Anemia 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Carcinomatosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 10/26 19 60 , to 12/11 19 60 , that (I) (the hospital) last saw the deceased alive on 12/19 19 60 , and that death occurred at 5 AM, from the causes and on the date stated above.			
22a. SIGNATURE Armon A. Cairo		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Armon A. Cairo		22d. ADDRESS Georgetown Univ. Hosp. - Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 13, 1960	
23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.	
24. FUNERAL DIRECTOR'S SIGNATURE B. Dangier & Sons ADDRESS 3501 - 14 St. NW.		25a. REC'D BY REGISTRAR DEC 14 '60 DATE	
		25b. REGISTRAR'S SIGNATURE Robert S. K...	

CERTIFICATE OF DEATH

14008

Montgomery

Montgomery

Montgomery

4 months Silver Spring

Silver Spring

1222 Silver Avenue

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Washington

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14107

14021

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 9107 Louis Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle Marcella Last DAVIES		4. DATE OF DEATH Month Dec Day 4 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28 1900
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George G. Simonds		14. MOTHER'S MAIDEN NAME MINNIE Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Husband Carnell Warren DAVIES Address (Same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteri Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 hr. 1 yr ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 17 1960 to Dec 4 1960 , that (I) (we) last saw the deceased alive on Dec 2 1960 , and that death occurred at 2:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE George Sharpe		22b. DATE SIGNED Dec 4 1960	
22c. PHYSICIAN'S NAME (Type) George Sharpe		22d. ADDRESS 10511 Summit Ave, Kensington, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 6, 1960	
23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S NAME AND ADDRESS Warner E. Pomfret, Inc. 8454 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR DEC 8 '60	
25b. REGISTRAR'S SIGNATURE Charles L. House			

CERTIFICATE OF SALE

11107

Whereas the undersigned, the State of Texas, do hereby certify that the following is a true and correct copy of the original as the same appears on the records of the State of Texas, to-wit:

County of Dallas, Texas

State of Texas

Recorded for the purpose of establishing a claim to the land described in the foregoing plat, to-wit:

Section 1, Township 10 North, Range 12 East, County of Dallas, State of Texas.

And whereas the said land is now owned by the State of Texas, and the same is being sold by the State of Texas, and the undersigned, the State of Texas, do hereby certify that the following is a true and correct copy of the original as the same appears on the records of the State of Texas, to-wit:

Section 1, Township 10 North, Range 12 East, County of Dallas, State of Texas.

Witness my hand and seal this 1st day of January, 1900.

Attest:

John W. Davis, Secretary of State

State of Texas

CERTIFICATE OF DEATH

Reg. Dist. No.

14022

14028

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & Hosp.</u>		d. STREET ADDRESS <u>405 ST. LAWRENCE DR.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Margaret Davis</u>		4. DATE OF DEATH Month Day Year <u>12 12 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-73</u>
9. AGE (In years last birthday) <u>87 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>TENN.</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>JAMES H. JULIAN</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET GAMBLE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. C. Edwin Davis, 405 St. Lawrence Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 422.1 DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>3 days</u> (c) <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Right Ribs 3-4-5-6-7.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 8</u> , 19 <u>60</u> , to <u>Dec 12, 1960</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>60</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George B. Patrick Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9221 Colesville Rd.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>George B. Patrick Jr. MD</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WARRENTON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WARRENTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>Silver Spring, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

• *Ch. 10*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14023

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

14108

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>8 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>4025 Plyers Mill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Susie Davis</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>19 60</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15, 1890</u>		9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Lydia Thomas</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daughter Same as Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetis 7 yrs.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/24/60</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 3 '61</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

70111

CERTIFICATE OF DEATH

Reg. Dist. No.

14024

14109

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda Rt 3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS O DAY</u>				4. DATE OF DEATH Month Day Year <u>12 / 3 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/13/1893</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>11 20</u>		IF UNDER 24 HRS. <u>11 20</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James W. Day</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Ricketts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		INFORMANT <u>4512 Great Oak Rd. Rockville, Md. daughter in law - Mrs. F. O Day Jr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Coronary atherosclerosis &</u> DUE TO (c) <u>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>undet.</u> <u>5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2/1957</u> to <u>12/3/1960</u> that I last saw the deceased alive on <u>12/3/1960</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>12/3/60</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Stephen N. Jones</u>				M.D. <u>12/3/60</u>			
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>				<u>809 Viers Mill Rd. Rockville, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14100

CERTIFICATE OF DEATH

Montgomery
Birmingham
Alabama

Montgomery
Birmingham
Alabama

BURBANK

FRANCIS

MARIE WHITE

Self Employed Contractor

12/3/60

DAY

X

Sample in hand - 1000
1000 - 1000
1000 - 1000

John F. Jones

1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14025
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14025
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>12 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>10 Valley View Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>William</u> Last <u>Detrich</u>		4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/19</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Detrich</u>		14. MOTHER'S MAIDEN NAME <u>Rose Klink</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>U.S. Hospital Records</u>	
17. INFORMANT <u>U.S. Hospital Records</u>		Address <u>U.S. Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute anterior coronary artery thrombosis - myocardial infarction</u> DUE TO (b) <u>Chronic fibrosis of myocardium</u> DUE TO (c) <u>Generalized hypertensive cardio-vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>20-30 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 12-18</u> , 19 <u>60</u> , to <u>12-18</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12-18</u> , 19 <u>60</u> , and that death occurred at <u>12:30</u> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest E. Harmon</u> M.D.		22b. DATE SIGNED <u>12-18-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ERNEST E. HARMON</u>		22d. ADDRESS <u>9301 Collesville Rd. Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 21, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walter</u>		25. REG. BY REGISTRAR <u>DEC 21 1960</u>	
ADDRESS <u>254 Carroll St N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14110

CERTIFICATE OF DEATH

14026

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1414 "C" Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Raymond Lee Dorsey		4. DATE OF DEATH Month December Day 11 Year 19 60					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 14, 1934	9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months 3 Days 11 Hours 19 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Teller		10b. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Washington, D.C.			
13. FATHER'S NAME Edward Dorsey		14. MOTHER'S MAIDEN NAME Florence Jenkins					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-14-3700		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Diabetes Mellitus DUE TO (c) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 3 months 24 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 26, 19 60 , to December 11, 19 60 , that I last saw the deceased alive on December 11, 19 60 , and that death occurred at 7:32 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Hibbard E. Williams		M.D. The Clinical Center		DATE SIGNED 12/12/60			
PHYSICIAN'S NAME (Type) Hibbard E. Williams, M.D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14 -60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill			
22d. LOCATION (City, town, or county) Suitland Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DEC 14 '60			
24b. REGISTRAR'S SIGNATURE Charles S. Kline							

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

15110

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO CLOSET

DATE OF ENTRY INTO BATH

DATE OF ENTRY INTO KITCHEN

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO AVENUE

DATE OF ENTRY INTO BOULEVARD

DATE OF ENTRY INTO PARKWAY

DATE OF ENTRY INTO HIGHWAY

DATE OF ENTRY INTO ROAD

DATE OF ENTRY INTO TRAIL

DATE OF ENTRY INTO PATH

DATE OF ENTRY INTO BRIDGE

DATE OF ENTRY INTO TUNNEL

DATE OF ENTRY INTO UNDERPASS

DATE OF ENTRY INTO OVERPASS

DATE OF ENTRY INTO VIADUCT

DATE OF ENTRY INTO CULVERT

DATE OF ENTRY INTO DRAINAGE

DATE OF ENTRY INTO SEWER

DATE OF ENTRY INTO WATER

DATE OF ENTRY INTO AIR

DATE OF ENTRY INTO EARTH

DATE OF ENTRY INTO SPACE

DATE OF ENTRY INTO TIME

DATE OF ENTRY INTO INFINITY

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14027

14111

Item 21 Film G277 12-23-60 et

1. PLACE OF DEATH o. COUNTY Montgomery M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 050 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		MARYLAND c. LENGTH OF STAY IN 1b 4 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Norfolk 83X=2 d. STREET ADDRESS 1021 Balview Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Roosevelt Last Dozier			4. DATE OF DEATH Month December Day 1 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1905	9. AGE (In years lost, birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Samuel Tyree		
14. MOTHER'S MAIDEN NAME Lydia Cherry			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 229-03-2105			17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Operative death DUE TO 411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute aortic incompetence DUE TO Severe atherosclerotic aortic valve disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from November 27 1960 , to December 1, 1960 , that (I) (we) lost 13:00 PM the deceased 12/2/60 and that death occurred 2:50 p.m. from the causes and on the date stated above.			
22a. SIGNATURE J.W. Gilbert		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/2/60	
22c. PHYSICIAN'S NAME (Type) J.W. Gilbert M.D.		22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 12-3-60		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery	
23d. LOCATION (City, town, or county) Norfolk, Virginia		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DEC 6 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14028

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day 4 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>5400 Glenwood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine</u> <u>devere</u> <u>Drayton</u>			4. DATE OF DEATH Month Day Year <u>12</u> <u>8</u> <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/7/78</u>		9. AGE (in years last birthday) <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Aiken, South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Charles Elliott Drayton</u>		
14. MOTHER'S MAIDEN NAME <u>Jessie Bowen E. Mackay</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT Address <u>Hospital Records- Bethesda, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible Brain Damage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Anoxia</u> (c) <u>Cardiac Arrest</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of rt hip</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down 3 steps at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12/7/60</u> <u>6:15 p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
20f. (City or town) <u>Bethesda</u>		20g. (County) <u>Montg.</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>12/8/60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory Prince Georges Co. Md.</u>	
22d. LOCATION (City, town, or county) <u>Ft. Lincoln Crematory Prince Georges Co. Md.</u>		22e. (State) <u>Md.</u>		22f. ADDRESS <u>The 8th Ave Co. 2901 1/2 St. N.W.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The 8th Ave Co.</u>		23a. REC'D BY REGISTRAR <u>DEC 12 '60</u>		23b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MINNESOTA MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15, 1920

5. Place of death: Home

6. Cause of death: Heart failure

7. Immediate cause: Myocardial infarction

8. Underlying cause: Coronary artery disease

9. Contributing causes: None

10. Manner of death: Natural

11. Signature of Medical Examiner: [Signature]

12. Date of certification: Jan 16, 1920

13. Signature of Registrar: [Signature]

14. Date of registration: Jan 16, 1920

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14007 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14029

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 5 yrs.	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10,208 PROCTOR STREET			d. STREET ADDRESS 10,208 PROCTOR STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ELMER Walter DUKE			4. DATE OF DEATH Month Day Year DEC. 14 1960		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/94	9. AGE (in years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME Walter A. Duke			14. MOTHER'S MAIDEN NAME Florence MARTHA SMELTZER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW #1 220-09-5348		17. INFORMANT Address Mrs. Gladys G. Duke, 10208 Proctor St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420-1 IMMEDIATE CAUSE (e) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Silver Spring, Md. INTERVAL BETWEEN ONSET AND DEATH Sudden					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Frank J. Broschart M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) FRANK J. BROSCART DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 12-152-60 DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
				22d. LOCATION (City, town, or country) (State) Prince George's Co., Md.	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC., Silver Spring, Md. Raymond A. Ziska			24a. REC'D BY REGISTRAR DEC 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna

50041

CERTIFICATE OF DEATH

Reg. Dist. No.

14030

14113

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodfield			c. LENGTH OF STAY IN 1b X Rural Woodfield		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS Rt. #1 Gaithersburg,		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Hilda Middle Pauline Last Duvall			4. DATE OF DEATH Month Dec. Day 11 Year 1960		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1896		9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Darius W. Burns			14. MOTHER'S MAIDEN NAME Campsidell Haines		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	INFORMANT Duvall Address Norman L. Woodstock Same as 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 175.0 IMMEDIATE CAUSE (a) Cancer of uterine cervix with generalized metastases DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 year					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from May 10, 1959 , to December 11, 1960 that I last saw the deceased alive on December 10, 1960 , and that death occurred at _____ M, from the causes and on the date stated above.					
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 12/13/60	
PHYSICIAN'S NAME (Type) Dr. James Kerr		Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 13, 1960	22c. NAME OF CEMETERY OR CREMATORY Jennings Chapel		22d. LOCATION (City, town, or county) (State) Howard County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber Laytonville Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 15 '60	24b. REGISTRAR'S SIGNATURE William S. Kramer

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14113

Blank form with faint horizontal lines for text entry.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14031

Item 8 Film 0278 1-6-61 et

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>	
c. LENGTH OF STAY IN 1b <i>S.O.A.</i>		d. STREET ADDRESS <i>604 - Alden Ave.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sharon Elaine Suval</i>		4. DATE OF DEATH <i>Dec. 27 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/11/69 1945</i>
9. AGE (In years last birthday) <i>15</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School girl.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Barnes Wm. Suval</i>	
14. MOTHER'S MAIDEN NAME <i>Helen E. King</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes give year or dates of service)</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 844X DUE TO (b) <i>Fracture of skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>She ran into large tree while sleigh riding</i>	
20c. TIME OF INJURY Hour <i>3:45</i> p.m. <i>12-27 1960</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>Back Farm</i>	20f. (City or town) <i>Montgomery</i> (County) <i>Boys</i> (State) <i>MD</i>
21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschant</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/30/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fairview</i>		22d. LOCATION (City, town, or country) <i>Proctorville Md.</i>	
23. FUNERAL DIRECTOR <i>Emory C. Fathner</i> ADDRESS <i>Faithersburg Md.</i>		24a. REC'D BY REGISTRAR <i>JAN 3 '61</i> DATE	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

Received of Mr. J. H. Smith
 the sum of \$10.00
 for rent of land
 11/11/60
 J. H. Smith
 11/11/60

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
14081
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14032

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 10 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 200 Harrison Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle ARTHUR Last ENGLAND		4. DATE OF DEATH Month Dec. 6, Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1883
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barliff		10b. KIND OF BUSINESS OR INDUSTRY Circuit Court	
11. BIRTHPLACE (State or foreign country) Rockville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John G. England		14. MOTHER'S MAIDEN NAME Annie Griffith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-28-16398	
17. INFORMANT Son		Address Rockville, M d.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Peritonitis 578X DUE TO Perforation of Transverse Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) also, obstructive jaundice due to common duct stone and bleeding 2 wks. (c) severe gastritis and peptic ulcer		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 21, 1960 to Dec 6, 1960 that (I) last saw the deceased alive on Dec 6, 1960 and that death occurred 8:15 M. from the causes and on the date stated above.			
22a. SIGNATURE Arthur F. Woodward		22b. DATE SIGNED 12-6-60	
22c. PHYSICIAN'S NAME (Type) ARTHUR F. WOODWARD		22d. ADDRESS 41 West Wood Lane, Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/60	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline		DATE DEC 8 '60	

14081

CERTIFICATE OF DEATH

Rockville

Rockville

Rockville

Rockville

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
14115											
CERTIFICATE OF DEATH											
14033											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)						c. LENGTH OF STAY IN 1b 12 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington					
						d. STREET ADDRESS 2811 Peregoy Drive					
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Jessie Muriel ENGLISH											
4. DATE OF DEATH Month Day Year December 27 1960											
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-21-78		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Canada				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James MC CORMICK						14. MOTHER'S MAIDEN NAME Mary PETTY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Grandson LtCol M.C. Murphy, USA, 15 Eton Ct., Alexandria, Va.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Primary Biliary cirrhosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 15 1960 to Dec. 27 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 27 1960 , and that death occurred at 6P M, from the causes and on the date stated above.											
22a. SIGNATURE R. G. Muth				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 12-28-60			
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 12-31-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons						ADDRESS 1756 Pa. Ave., NW, WashDC		25a. REC'D BY REGISTRAR DEC 30 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kneib	

12 days (1954-1955)

1040410

• *Chlorophyll a* (Chl a) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue and red regions of the visible spectrum. Chl a is essential for the light-dependent reactions of photosynthesis, where it converts light energy into chemical energy in the form of ATP and NADPH.

300 Central Ave., New York 17, N.Y.

CERTIFICATE OF DEATH

Reg. Dist. No.

14034

14008

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>201 QUANT ACRES DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>Daniel</u> Last <u>Feick</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>85</u> Days <u>85</u> Hours <u>85</u> Min. <u>85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber (Self-employed)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Feick</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>186 28 7564</u>	
INFORMANT <u>Gertrude McKenna</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Hypertensive arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u> <u>6 mo</u> <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1, 1956</u> to <u>Dec. 7, 1960</u> , that I last saw the deceased alive on <u>Dec. 7, 1960</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond Bradshaw</u> M.D.		ADDRESS (Street, city or town, state) <u>345 University Blvd, West</u> DATE SIGNED <u>12/1/60</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, TRANS. & BURIAL 12/10/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>VERSAILLES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>McKEESPORT, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15008

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15 1908*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Signature of physician: *Dr. J. Smith*
8. Signature of registrar: *John Doe*
9. Date of registration: *Jan 15 1908*
10. Place of registration: *New York City*

CERTIFICATE OF DEATH

Reg. Dist. No.

14035

14116

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville		c. LENGTH OF STAY IN 1b 60 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Spencer Last Fisher		4. DATE OF DEATH Month December Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 16-1894
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier---U.S.Gov.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Millard C. Fisher		14. MOTHER'S MAIDEN NAME Mary E. Boswell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-18-1572	
17. INFORMANT Mrs Spencer Fisher, Barnesville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
INTERVAL BETWEEN ONSET AND DEATH 30 hours 5 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Dec , 19 60 , to 4 Dec , 19 60 , that I last saw the deceased alive on 4 Dec , 19 60 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DAWSONVILLE DATE SIGNED 12/5/60			
ACTUAL SIGNATURE John C. Fawcett		PHYSICIAN'S NAME (Type) JOHN C. FAWCETT M.D. P.C. BOYDS, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12/7/60	St Marys	Barnesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR DEC 9 '60	
ADDRESS Barnesville, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

County

Maryland

Barrenville

60 yrs

Barrenville

Barrenville

Barrenville

November 10-1888

Barrenville

Barrenville

Barrenville

Barrenville

Barrenville

Barrenville

Barrenville

Barrenville

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Barrenville

1. **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14030

CERTIFICATE OF DEATH

14036

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>12 hrs</u>				d. STREET ADDRESS <u>7304 Birch Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Scenicview Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lillian Ada Fisher</u>				4. DATE OF DEATH <u>Dec. 6 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-24-08</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles E. Pyle</u>				14. MOTHER'S MAIDEN NAME <u>Florence McCluskey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-12-1387</u>		17. INFORMANT <u>Hospital Admitting Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8 CARCINOMA OF COLON</u> DUE TO (b) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>12-5 1960</u> to <u>12-6 1960</u> that (I) (we) last saw the deceased alive on <u>12-6 1960</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>L. B. SNOW</u>				22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <u>L. B. SNOW</u>	
22d. ADDRESS <u>7950 New Hampshire Ave., Langley Park, Md.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		23d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pompey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>DEC 14 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Quincy L. Thomas</u>	

14030

CENTRAL OF OAHU

14030

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "CENTRAL OF OAHU" and "14030" are visible.]

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14037

14117

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 28 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Violet Middle Sylvia Last Frankhouser		4. DATE OF DEATH Month December Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 20, 1910
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR: Months 50 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis S. Yassel		14. MOTHER'S MAIDEN NAME Olga Kerkow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record Address The Clinical Center		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) 493X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) 24 hours INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from November 21, 1960 to December 19, 1960 , that (we) last saw the deceased alive on Dec. 19, 1960 , and that death occurred at 1:29 AM from the causes and on the date stated above.			
22a. SIGNATURE Sanford F. Kuvin, M.D.		22b. DATE SIGNED 12/19/60	
22c. PHYSICIAN'S NAME (Type) Sanford F. Kuvin, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/60	
23c. NAME OF CEMETERY OR CREMATORY Palmer Memorial Park		23d. LOCATION (City, town, or county) (State) Fall Church, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home		25a. REC'D BY REGISTRAR DEC 23 '60	
ADDRESS 5103 Wisconsin		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF TEST

1117

Examination of

Witness

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Witness

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

14118

14118

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14038

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 53 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1425 Webster St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Josephine Brown FRANKLIN		4. DATE OF DEATH Month Day Year December 2 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-97
9. AGE (In years last birthday) 63 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse-Attendant		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. BROWN		14. MOTHER'S MAIDEN NAME Serena CALLEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (H) John W. Franklin, 3108 Park Place, N.W.	
17. INFORMANT Washington, DC		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction, right middle and lower lobes. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embolus, pulmonary artery, right DUE TO (c) Phlebotrombosis, left common iliac	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Oct. 10 1960 to Dec. 2 1960 , that (X) (we) last saw the deceased alive on Dec. 2 1960 , and that death occurred at 8:29AM from the causes and on the date stated above.			
22a. SIGNATURE F. M. Highly, Jr.		22b. DATE SIGNED 12-2-60	
22c. PHYSICIAN'S NAME (Type) F. M. HIGHLY, JR., LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Magruder Funeral Home, 2311 Nicholas Ave., S.E.		25a. REC'D BY REGISTRAR DEC 7 '60	
25b. REGISTRAR'S SIGNATURE Andrew S. Thrash			

CERTIFICATE OF DEATH

1918

State of Colorado

Washington

23 days

Death (1918)

1918 Washington St., N.W.

U. S. Naval Hospital

FRANKLIN

Brown

Josephine

28

9-11-17

Home

Yuma

U.S.A.

Washington, D. C.

Hospital

Home-Ascendant

George GARRA

John R. BROWN

Washington, D.C.

(H) John W. Franklin, 1103 First Street, N.W.

No

Dec. 2

Dec. 10

Dec. 2

12-2-00

F. M. HUGHES, JR., LT. MC, USN, U. S. Naval Hospital, Bethesda, Md.

Virginia

Washington

Washington National

12-1-00

1918

Funeral Home, 2311 Nichols Ave., S.E.

CERTIFICATE OF DEATH

Reg. Dist. No. 14039

14068

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home			d. STREET ADDRESS 83X-3		
3. NAME OF DECEASED (Type or print) First Kate Middle Aiken Last Frasier			4. DATE OF DEATH Month 12 Day 30 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1867		9. AGE (In years last birthday) 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home work	11. BIRTHPLACE (State or foreign country) Cass County, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Thomas William Frasier			14. MOTHER'S MAIDEN NAME Eliza Aiken		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450-0 IMMEDIATE CAUSE (a) Generalized Arteriosclerosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
INTERVAL BETWEEN ONSET AND DEATH Years					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10-20 , 19 60 , to 12-30 , 19 60 that I last saw the deceased alive on 12-29 , 19 60 , and that death occurred at 2:20 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE James W. Egan		M.D. 7720 Wisconsin Ave.		DATE SIGNED 12-30-60	
PHYSICIAN'S NAME (Type) JAMES W. EGAN, Md.		ADDRESS Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-61		22c. NAME OF CEMETERY OR CREMATORY Iva Hill	
				22d. LOCATION (City, town, or county) (State) Upperville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.			ADDRESS Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE JAN 4 '61
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1:00

CERTIFICATE OF DEATH

DEPARTMENT

HEALTH

Assembly Recording Room

Date

Female, White

Married

Thomas William Stender

Eliza Allen

April 10, 1907

Case County, Mo.

W. D. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14040

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 3 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Westgate)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Congressional Manor Sanitarium				d. STREET ADDRESS 5142 Worthington Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSE Middle GERHARDT Last GERHARDT				4. DATE OF DEATH Month Dec. Day 2, Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1872		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Schneider				14. MOTHER'S MAIDEN NAME Lauckhardt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Son Harrison A. Gerhardt Address Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Sigmoid 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Dec. 2, 1960			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-2-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, New York	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE DEC 6 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

14041

14120

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District Of Columbia b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 417 - 12th Street, S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Carroll Middle Robert Last Gibbs				4. DATE OF DEATH Month December Day 1 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 31, 1915	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 47 Days X Hours 3		IF UNDER 24 HRS. Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Gibbs				14. MOTHER'S MAIDEN NAME Elizabeth Berry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 578-22-0716			
17. INFORMANT The Medical Records				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Head of Pancreas with invasion of DUE TO Gastro-jejunoscopy. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive Gastro-intestinal hemorrhage DUE TO hours (c) hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 Years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 1960 Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 25, 1960 , to December 1, 1960 that I last saw the deceased alive on December 1, 1960 , and that death occurred at 6:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/3/60 NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND							
ACTUAL SIGNATURE Robert B. Scoggins, M.D.				PHYSICIAN'S NAME (Type) Robert B. Scoggins, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Fort Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Alexander S. Pope				ADDRESS 414 15th. St. S. E.		24a. REC'D BY REGISTRAR DATE DEC 5 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

STATEMENT OF DEATH

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State of California

County of

The County of

Age

Sex

Married

Occupation

Signature of

Signature of

Signature of

Witness

Witness

Signature of

Signature of

Signature of

Signature of

VR A1S (4)
1SM 9/59

14121



47X-3

CERTIFICATE OF DEATH

14121

State of Indiana

County of

City of

Age

Sex

Date of Birth

Date of Death

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Signature of Registrar

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14009

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

14043

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 7 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2812 DAWSON STREET				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 2812 DAWSON STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FREDERICK William GLANTZ First Middle Last				4. DATE OF DEATH December 6, 1960 Month Day Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 10, 1872	
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY (retired)				10b. KIND OF BUSINESS OR INDUSTRY Pa. Welfare Board		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHRISTIAN GLANTZ				14. MOTHER'S MAIDEN NAME CATHERINE STRAHLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Elsie S. Glantz, 2812 Dawson St. Silver Spring, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Heart Disease DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs. 5 yrs. 15 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1953 to 12/6/60 , that (I) (we) last saw the deceased alive on Sept. 29, 1960 , and that death occurred at 12 noon from the causes and on the date stated above.							
22a. SIGNATURE Belden R. Reap M.D. 22b. DATE Dec. 6, 1960							
22c. PHYSICIAN'S NAME (Type) BELDEN R. REAP, M.D. 22d. ADDRESS 11502 GRANDVIEW AVENUE, SILVER SPRING, MARYLAND.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/9/60		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPHREY, INC. <i>Raymond C. Zucka</i>				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DEC 14 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kram			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14003

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14069

CERTIFICATE OF DEATH

Reg. Dist. No.

14044

1. PLACE OF DEATH a. COUNTY Montg MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Flossie Pearl Graham				4. DATE OF DEATH Dec 21 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 18th 1907		9. AGE (In years last birthday) 53 yrs	10. IF UNDER 1 YEAR 0 Months 3 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY " "		11. BIRTHPLACE (State or foreign country) Taswell Va.	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME James H. Collins			
14. MOTHER'S MAIDEN NAME Nolan (Lanola)				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Geraldine Lith. Gaithersburg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO 002X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerosis DUE TO Bronchitis (c) Bronchitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 58 , 19 58 , to Dec 21 , 19 60 that I last saw the deceased alive on Dec 21 , 19 60 , and that death occurred at 7 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Luciano I. Leal M.D.				ADDRESS (Street, city or town, state) Gaithersburg Md.			
PHYSICIAN'S NAME (Type) Luciano I. Leal				DATE SIGNED Dec 27 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-60		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. ADDRESS Gaithersburg. Md.				24a. REC'D BY REGISTRAR DEC 27 1960		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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Director, U.S. Forest Service
Washington, D.C.
1978

Dear Sir:
Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.
Very truly yours,
[Signature]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14045

14031

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7025 EASTERN AVE.</u>		e. STREET ADDRESS <u>7025 EASTERN AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRIETT</u> Middle <u>M.</u> Last <u>GRAYBILL</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 19, 1878.</u>
9. AGE (In years, lost birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>IOWA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN F. RUBEL</u>		14. MOTHER'S MAIDEN NAME <u>GILLIAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MAE RUTH R. G. HALL</u>		Address <u>TAK PR MD. 7025 EASTERN AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/8</u> 19 <u>60</u> , to <u>12/19</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> 19 <u>60</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James R. Coleman MD.</u>		22b. DATE SIGNED <u>12/20/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		22d. ADDRESS <u>733 Sleigo Avenue, Silver Spring MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC 21, '60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MAPLETON, IOWA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>WASH DC. 254 Carroll ST NW.</u>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>DEC 23 '60</u>			

CERTIFICATE OF DEATH

14031

1

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

14122

14046

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		45	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5924 Johnson Avenue		d. STREET ADDRESS 5924 Johnson Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacqueline Middle V Last Grosso		4. DATE OF DEATH Month 12 Day 14 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Sicily		12. CITIZEN OF WHAT COUNTRY? US-Naturalized	
13. FATHER'S NAME James Vaiana		14. MOTHER'S MAIDEN NAME Mary Ferrara	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Henson, Daughter-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Atherosclerotic Heart Disease DUE TO Chronic Phlebitis (c) Chronic Phlebitis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 12/14 , 19 60 , that (I) (we) lost saw the deceased alive on 12/13 , 19 60 , and that death occurred at 3P M. from the causes and on the date stated above.			
22a. SIGNATURE W. T. Joyce		22b. ADDRESS 8106 Maple Ridge Rd. Beth. Md.	
22c. PHYSICIAN'S NAME (Type) William T. Joyce		22d. ADDRESS 8106 Maple Ridge Rd. Beth. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/60	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town, or county) (State) Nesquehoning, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE DEC 20 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

1433

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
Coroner of Mont Co - Dr Frank Proschy notified asked Dr James Laubach to sign certificate

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14032

CERTIFICATE OF DEATH

14047

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md. D.O.A.				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 26							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp.				d. STREET ADDRESS 2220 Washington Ave.				e. IS RESIDENCE ON A FARM? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Alexander Herbert Grolman				4. DATE OF DEATH 12 25 1960				5. AGE (In years last birthday) 69 yrs.							
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-91		9. IF UNDER 1 YEAR Months Days Hours Min.		10. IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Men's Wear				11. BIRTHPLACE (County & State, or foreign country) Maryland							
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Isaac Grolman				14. MOTHER'S MAIDEN NAME Emma Deutsch.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W W I				16. SOCIAL SECURITY NO. 519-01-1730				17. INFORMANT Ira Grolman							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) Acute Myocardial Infarction DUE TO 1 HOUR				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) 12/25/60				20g. (County)				20h. (State)							
21. I certify that (I) (this hospital) attended the deceased from 12/25/60 to 12/25/60, that (I) (we) last saw the deceased alive on 12/25/60, and that death occurred at 9:45 PM, from the causes and on the date stated above.															
22a. SIGNATURE James L. Laubach				22b. DATE SIGNED 12/25/60				22c. PHYSICIAN'S NAME (Type) JAMES L. LAUBACH, M.D.							
22d. ADDRESS 1806 Fox St, Hyattsville, Md.				22e. REC'D BY REGISTRAR DEC 28 '60				22f. REGISTRAR'S SIGNATURE Arthur L. Kinner							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 12-27-60				23c. NAME OF CEMETERY OR CREMATORY NAT'L MEM. PARK							
23d. LOCATION (City, town or county) FALLS CHURCH, VA.				23e. (State) VA.				23f. (Country)							
24. FUNERAL DIRECTOR'S SIGNATURE Goedberg Funeral Home												24b. ADDRESS 4217-9th St NW DC			

86021



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

2

2

VS. A15ME
5M 7/59

14010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14048

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>14 years</u>				d. STREET ADDRESS <u>1 804 Thayer Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>804 Thayer Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MAUD L. Gumm</u>				4. DATE OF DEATH <u>Dec 23 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-29-1896</u>	
9. AGE (In years last birthday) <u>70 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>la</u>	
13. FATHER'S NAME <u>FRANK SHERMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE JONES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Sam. L. Gumm Jr</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO (b) <u>Cerebral hemorrhages</u> DUE TO (c) <u>Fractured Skull</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reputed beaten with an iron pipe</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>?</u> p.m. <u>12-23 1960</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Monty</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bloeschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Bloeschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>12-24-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR <u>Warner & Humphrey Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

14010 MEDICAL EXAMINATION CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*
2. Date of Birth: *10/15/1920*
3. Sex: *Male*
4. Race: *White*
5. Marital Status: *Married*
6. Occupation: *Teacher*
7. Address: *123 Main St, Anytown, USA*
8. Date of Death: *11/10/1980*
9. Time of Death: *10:30 AM*
10. Place of Death: *Home*
11. Cause of Death: *Heart Disease*
12. Manner of Death: *Natural*
13. Signature of Physician: *[Signature]*
14. Signature of Medical Examiner: *[Signature]*
15. Signature of Coroner: *[Signature]*

DEC 5 1980

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14123

14849

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 4510 Baltimore Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nels Middle HAGE Last HAGE				4. DATE OF DEATH Month December Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-86		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nels Hage				14. MOTHER'S MAIDEN NAME Sigri Hanstotter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerotic Heart Disease (c) 5 years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 20, 1960 to Dec. 21, 1960 , that (X) (we) last saw the deceased alive on Dec. 21, 1960 , and that death occurred at 2:35AM from the causes and on the date stated above.							
22a. SIGNATURE William P. Baker				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-21-60	
22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Son				ADDRESS Gasch's Funeral Home, Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 27 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hirsch			

051

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1

CERTIFICATE OF DEATH

14123

Decemur 21 1900

U. S. Naval Hospital, Portsmouth, N.H.

U. S. Naval Hospital, Portsmouth, N.H.

Decemur 21 1900

U. S. Naval Hospital, Portsmouth, N.H.

U. S. Naval Hospital, Portsmouth, N.H.

U. S. Naval Hospital, Portsmouth, N.H.

U. S. Naval Hospital, Portsmouth, N.H.

X

Dec. 20 1900

5:30 PM

Dec. 21 1900

12-21-00

U. S. Naval Hospital, Portsmouth, N.H.

U. S. Naval Hospital, Portsmouth, N.H.

U. S. Naval Hospital, Portsmouth, N.H.

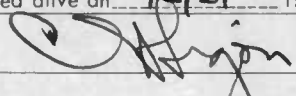
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14124

14050

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERBERT Middle ELMER Last HALL				4. DATE OF DEATH Month DECEMBER Day 27 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/7/1884	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY CAR DEALER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN HALL				14. MOTHER'S MAIDEN NAME JANE PHAR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Hypertensive Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 1 week Yrs Yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 56 to 12/27 , 19 60 , that (I) (we) last saw the deceased alive on 12/27 , 19 60 , and that death occurred at 1000 M, from the causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/27/60	
22c. PHYSICIAN'S NAME (Type) CHARLES H. LIGON, M. D.				22d. ADDRESS SANDY SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/60		23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery Highland, Md		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE DeWitt Canathan, Laurel, Md				25a. RECEIVED BY REGISTRAR DATE JAN 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

1-630

CERTIFICATE OF DEATH

14124

NAME: JAMES H. HARRIS
AGE: 35 YEARS
SEX: MALE
DATE OF BIRTH: JANUARY 15, 1900
PLACE OF BIRTH: NEW YORK
OCCUPATION: CLERK
CAUSE OF DEATH: HEART DISEASE
DATE OF DEATH: JANUARY 20, 1935
PLACE OF DEATH: NEW YORK
SIGNATURE: J. H. HARRIS
TESTIFYING PHYSICIAN: J. H. HARRIS

[Faint, illegible handwritten text, possibly a signature or additional notes.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14051

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>				d. STREET ADDRESS <u>514 Cannon Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GAIL</u> First <u>Gail</u> Middle <u>W.</u> Last <u>Hammer</u>				4. DATE OF DEATH <u>12 12 1960</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/02</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PePco Troubledesk Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRED W. HAMMER</u>				14. MOTHER'S MAIDEN NAME <u>CORA HITCHCOCK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>577-09-3536</u>		17. INFORMANT <u>Mrs. Catherine F. Hammer</u> Address <u>514 Cannon Road Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bloschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Bloschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-12-60</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14011

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14052

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 STIRLING ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle FRANCIS Last HANRAHAN, JR.		4. DATE OF DEATH Month DECEMBER Day 17 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/96
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN (Woodward & Lothrop)		10b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES F. HANRAHAN, SR.		14. MOTHER'S MAIDEN NAME NETTIE M. DOVE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 577-01-4765	
17. INFORMANT Mrs. Mary Agnes Hanrahan, 505 Stirling Rd. Silver Spring, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4204 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 16 19 60 , to Dec 17 19 60 , that (I) (we) last saw the deceased alive on Dec 17 19 60 , and that death occurred at 4 M, from the causes and on the date stated above.			
22a. SIGNATURE J. Raymond Ready		22b. DATE SIGNED 12/17/60	
22c. PHYSICIAN'S NAME (Type) J. RAYMOND READY		22d. ADDRESS 3701 LELAND ST., CHEVY CHASE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/21/60	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR DEC 27 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Carlton L. Kraus	

14053

RECEIVED
CENTRAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

11011

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including dates and names, but the specific details cannot be discerned.]

1

CERTIFICATE OF DEATH

1412

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]
12. Place of registration: [illegible]

CHIEF TAIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14034 CERTIFICATE OF DEATH 14054									
1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md. c. LENGTH OF STAY IN lb 10X days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 1018 Heather Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Hamilton Harding Harrison			4. DATE OF DEATH Month December Day 20 Year 1960						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-81	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - D.C. Fire Department			11. BIRTHPLACE (County & State, or foreign country) Village, Virginia			12. CITIZEN OF WHAT COUNTRY America			
13. FATHER'S NAME Wm. James Harrison			14. MOTHER'S MAIDEN NAME Hester Reynolds						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)			16. SOCIAL SECURITY NO. no		17. INFORMANT Clara Elizabeth Harrison Address 1018 Heather Ave. Takoma Park, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vascular collapse and anoxia 30 minutes 193.3 DUE TO (b) Surgery for brain tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) left frontal malignant brain tumor 6 weeks									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/12/60 to 12/20/60 that (I) (we) last saw the deceased alive on 12/20/60 and that death occurred at 2:40 P.M. from the causes and on the date stated above.									
22a. SIGNATURE John T. Lord M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/20/60				
22c. PHYSICIAN'S NAME (Type) John T. Lord			22d. ADDRESS 1015 Spring St. Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12/24/60		23c. NAME OF CEMETERY OR CREMATORY Carmel Methodist Church		23d. LOCATION (City, town or county) (State) Kinsale, Westmoreland Co. Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.			ADDRESS 2901 14th Street, N.W. Washington 9, D.C.		25a. REC'D BY REGISTRAR DEC 23 '60		25b. REGISTRAR'S SIGNATURE Arthur E. Hines		

Reported to and approved by Montgomery County -
Medical Examiner. 12-20-60 -- 3:00 P.M.

John T. Lord, MD
12-20-60

CERTIFICATE OF DEATH

Reg. Dist. No.

14055

14035

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Silver Spring,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 121 Whitmoor Terrace	
3. NAME OF DECEASED (Type or print) First Middle Last Hart		4. DATE OF DEATH Month Day Year December 14 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Maryland	
13. FATHER'S NAME Humes Houston Hart		14. MOTHER'S MAIDEN NAME Laura Carter Rowse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		father	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis fetalis 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH since birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral pulmonary atelectasis, very severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 14, 1960 , to Dec 14, 1960 , that I last saw the deceased alive on Dec 14, 1960 , and that death occurred at 7:55 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Elizabeth Chickering M.D.			
PHYSICIAN'S NAME (Type) Elizabeth Chickering, M. D.		3601 Connecticut Ave., N.W. Wash. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12-14-60	22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium and Hospital		24a. REC'D BY REGISTRAR DEC 19 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

2075292XV4

CERTIFICATE OF DEATH

14015

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. EDUCATION College		12. RELIGION Methodist		13. PRESENT ADDRESS 201 West Lexington Ave., Memphis, Tennessee		14. DATE OF DEATH April 4, 1968		15. PLACE OF DEATH Memphis, Tennessee	
16. CAUSE OF DEATH Gunshot wound		17. MANNER OF DEATH Suicide		18. MEDICAL HISTORY None		19. PRESENT ILLNESS None		20. POSTMORTEM EXAMINATION None	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF NEXT OF KIN None		23. SIGNATURE OF PHYSICIAN None		24. SIGNATURE OF CORONER None		25. SIGNATURE OF JURY None	
26. SIGNATURE OF REGISTRAR None		27. SIGNATURE OF CLERK None		28. SIGNATURE OF ASSISTANT CLERK None		29. SIGNATURE OF CHIEF CLERK None		30. SIGNATURE OF DEPUTY CHIEF CLERK None	

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death.
2. The name of the deceased must be written in full, including the last name, first name, and middle name or initial.
3. The sex of the deceased must be written as male or female.
4. The age of the deceased must be written in years and months.
5. The date of birth must be written in full, including the day, month, and year.
6. The place of birth must be written in full, including the city, county, and state.
7. The occupation of the deceased must be written in full.
8. The marital status of the deceased must be written as single, married, widowed, or divorced.
9. The color of the deceased must be written as white, black, or other.
10. The height of the deceased must be written in feet and inches.
11. The weight of the deceased must be written in pounds.
12. The education of the deceased must be written as none, high school, college, or other.
13. The religion of the deceased must be written in full.
14. The present address of the deceased must be written in full, including the street, city, county, and state.
15. The date of death must be written in full, including the day, month, and year.
16. The place of death must be written in full, including the city, county, and state.
17. The cause of death must be written in full, including the name of the disease or injury and the organ or system affected.
18. The manner of death must be written as natural, suicide, homicide, or other.
19. The medical history of the deceased must be written in full, including the name of the disease or injury and the organ or system affected.
20. The present illness of the deceased must be written in full, including the name of the disease or injury and the organ or system affected.
21. The postmortem examination of the deceased must be written in full, including the name of the disease or injury and the organ or system affected.
22. The signature of the deceased must be written in full, including the name and address.
23. The signature of the next of kin must be written in full, including the name and address.
24. The signature of the physician must be written in full, including the name and address.
25. The signature of the coroner must be written in full, including the name and address.
26. The signature of the jury must be written in full, including the name and address.
27. The signature of the registrar must be written in full, including the name and address.
28. The signature of the clerk must be written in full, including the name and address.
29. The signature of the assistant clerk must be written in full, including the name and address.
30. The signature of the chief clerk must be written in full, including the name and address.
31. The signature of the deputy chief clerk must be written in full, including the name and address.

1
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14126

CERTIFICATE OF DEATH

Reg. Dist. No.

14056

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Halfpenny</u> Last <u>Hartranft</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> Clerk - Federal Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Abigail B. Dubois</u>		14. MOTHER'S MAIDEN NAME <u>Eisenwine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Alda Hise</u>		Address <u>9804 Cable Dr. Kensington Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>irreversible shock</u> 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Infarction of ileum + jejunum</u> (c) <u>Mesenteric Venous thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>27h</u> <u>2-3 days</u> <u>UNK.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 6, 1960</u> , to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>60</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhou</u>		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u>	
PHYSICIAN'S NAME (Type) <u>John B. Umhou</u>		DATE SIGNED <u>12/16/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>12/18/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Muncy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Muncy, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

14128

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

Blank lines for text entry.

Signature: _____
Date: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14127 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14057

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7914 - 15th. Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Frank I. Hawa</u>		4. DATE OF DEATH <u>Dec. 12 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25 1886</u>
9. AGE (in years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) <u>Bagdad Turkey</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>un known</u>		14. MOTHER'S MAIDEN NAME <u>un known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Isadore Hawa</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>434 J</u> IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-15-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETH SHOLOM CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSIDE - MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY & SONS - 3501-14th Ave</u>		24a. REC'D BY REGISTRAR <u>DEC 20 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Flann</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

(1)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
14128 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
14058																			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg (R7L)</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg R7L</u>														
c. LENGTH OF STAY IN 1b <u>life</u>					d. STREET ADDRESS <u>Burnt Hills Rd</u>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Burnt Hills Rd</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>Colethia Denise Hawkins</u>					4. DATE OF DEATH <u>Dec 28 1960</u>														
5. SEX <u>female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 25- 58</u>		9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>					11. BIRTHPLACE (State or foreign country) <u>md</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					13. FATHER'S NAME <u>Hamilton A Hawkins</u>					14. MOTHER'S MAIDEN NAME <u>Madeline Hebron</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>					16. SOCIAL SECURITY NO. <u>-</u>					17. INFORMANT <u>Madeline Hawkins</u> Address <u>Ston 2</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burn involving entire body, head & extremities</u> DUE TO (b) <u>Fire of home</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) <u>Was in bed when house burned</u>					20c. TIME OF INJURY Month, Day, Year <u>8:45 p.m. 12-28 1960</u>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>					20f. (City or town) <u>Clarksburg Montg md</u> (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED				
ACTUAL SIGNATURE <u>Franz J. Broschack</u> M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) <u>FRANK J. Broschack</u>					Address (Street, city, town, or county) <u>12-28-60</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Dec. 31, 1960</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>									
22d. LOCATION (City, town, or country) <u>Purdum, Md.</u>					22e. (State) <u>md</u>														
23. FUNERAL DIRECTOR <u>Ulin L. Molewath</u>					ADDRESS <u>Damascus, Md.</u>					24a. REC'D BY REGISTRAR <u>JAN 4 '61</u> DATE									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>																			

THE STATE
DEPARTMENT OF HEALTH

1

1

1

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14129 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14059

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cabin John Bethesda D.O.A. c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 58 Cabin John d. STREET ADDRESS 19 Carver Rd., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Ethel Mae Henderson		4. DATE OF DEATH Month 12 Day 29 Year 19 60		5. SEX F		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/12/23		9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 12 Days 29		11. IF UNDER 24 HRS. Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY D.C.				11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Tate				14. MOTHER'S MAIDEN NAME Elizabeth Thompson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. 581.0				17. INFORMANT William Henderson (husband) same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fat Embolism 581.0 DUE TO (b) Hepatic Fatty Metamorphosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Unknown INTERVAL BETWEEN ONSET AND DEATH Unknown												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) Washington - D.C.		(County) D.C.		(State) D.C.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Brosch				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12-30-60							
EXAMINER'S NAME (Type) FRANK J. BROSCH				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) 12-30-60											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-4-61		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) Washington - D.C.		(State) D.C.		23. FUNERAL DIRECTOR Robert L. Snowden									
ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE JAN 4 '61		24b. REGISTRAR'S SIGNATURE William E. Howard													

MEDICAL CERTIFICATION

CS44

[illegible]

1507112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A13 (4)
15M 9/55

14036

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert. et

CERTIFICATE OF DEATH

Reg. Dist. No.

14060

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		d. STREET ADDRESS Apt. 101 13 Manchester Pl. Wayne Apts.	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert		4. DATE OF DEATH Month Day Year December 12, 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1960
9. AGE (In years last birthday) — yrs.		IF UNDER 1 YEAR Months Days Hours Min. — 2 — —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Takoma Park, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Mitchell Herbert		14. MOTHER'S MAIDEN NAME Patricia Mary Hannell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Winston E. Cochran		M.D. 927 Pershing Dr., Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Winston E. Cochran, M. D. same as above.....			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12-13-60	22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D.		24a. REC'D BY REGISTRAR DEC 15 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Hines			

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CONFIDENTIAL

14130

14

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14131

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14062

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN <u>2 mo. 2 da.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1960</u>			5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>Dec. 20, 1872</u>			9. AGE (In years lost birthday) <u>88</u> yrs.		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN (retired)</u>			11. BIRTHPLACE (State or foreign country) <u>Round Hill Va.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Joseph Hill</u>		
14. MOTHER'S MAIDEN NAME <u>SARAH LODGE</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>579-38-3669</u>			17. INFORMANT <u>Mrs Ernest L. Hill</u> Address <u>8208 Roanoke Takoma Park Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Varicella Pneumonia</u> DUE TO (b) <u>Cardiac failure</u> DUE TO (c) <u>Senile Degeneration of heart. Schistosomiasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 6, 1960</u> to <u>Dec 22, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 20, 1960</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>John B. Ziegler M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>12/22/60</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>			22d. ADDRESS <u>OLNEY, MARYLAND</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pimphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>			25a. REC'D BY REGISTRAR <u>DEC 29 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

14131



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tokoma Park</u>		c. LENGTH OF STAY IN TB <u>34</u> <u>Wheaton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sant. Hospital</u>		d. STREET ADDRESS <u>12712 Feldon St.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCES V. HILLEY</u>		4. DATE OF DEATH <u>December 24</u> 19 <u>60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1918</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statically clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charly F. Fairfax</u>		14. MOTHER'S MAIDEN NAME <u>Constance Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Doyle R. Hilley 12712 Feldon St. Wheaton</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerotic vascular disease years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/22</u> , 19 <u>60</u> to <u>12/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/24</u> , 19 <u>60</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Charles M. Weber, M.D.</u>			
ACTUAL SIGNATURE <u>Charles M. Weber, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Charles M. Weber M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 29 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington Va.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Deal Funeral Home 4812 Ga. Ave. D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14064

14132

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Glenn Middle D Last Hively		4. DATE OF DEATH Month December Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 15, 1913
9. AGE (In years lost birthday) yrs. 47		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Walter A. Hively		14. MOTHER'S MAIDEN NAME Sarrah Simmons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army		16. SOCIAL SECURITY NO. INFORMANT (wife) Mrs. Mary L. Hively Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis, coronary Arteries DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12:00 to DEC 5, 1960 , that I last saw the deceased alive on Dec 4, 1960 , and that death occurred at 12:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P. L. Tabb, M.D.		ADDRESS (Street, city or town, state) 13000 GEORGIA AVE - S.W. Sp. Md 17th	
PHYSICIAN'S NAME (Type) Samuel L. Tabb		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/7/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Elton Va.		22d. LOCATION (City, town, or county) (State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thau		24a. REC'D BY REGISTRAR DATE DEC 7 '60	
24b. REGISTRAR'S SIGNATURE			

(M)

074

(I)

2

47X-2

5732 Ya Ave
 DC

1964

CERTIFICATE OF DEATH

14132

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF REGISTRAR

NAME OF CLERK

NAME OF JUDGE

NAME OF SHERIFF

NAME OF DEPUTY SHERIFF

TO HOSPITAL CEMETERY ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

14133

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14065

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1901 K Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Reginald P. HODGDON		First Middle Last		4. DATE OF DEATH December 6 19 60		Month Day Year	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-92		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Parklin HODGDON				14. MOTHER'S MAIDEN NAME Jenny ORNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. XXXX WWI-WWII 577-58-1956		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.0 acute pancreatitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 4 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Nov. 21 19 60 to Dec. 6 19 60 that (X) (we) last saw the deceased alive on Dec. 6 19 60 , and that death occurred at 9:20PM M, from the causes and on the date stated above.							
22a. SIGNATURE B H Rice				22b. DATE SIGNED 12-7-60		22c. PHYSICIAN'S NAME (Type) B. H. RICE, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22e. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 12-7-60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		23d. LOCATION (City, town, or county) (State) Gloucester Mass.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W.Chambers Co., 1400 Chapin St., NW, WashDC				ADDRESS		25a. REC'D BY REGISTRAR DEC 8 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

W.W. Chambers Co., 1400 Chapin St., New York

Bureau of Information 15-7-60 Cherry Hill Cemetery Gloucester Mass.

F. M. Rice, Lt. Col., USN U. S. Naval Hospital, Bethesda, Md.

12-7-60 X

Dec. 6 60

Nov. 21 9:00 AM 60

Dec. 6 60

X

Continued

Bethesda (Honor)

15 days

Washington

U. S. Naval Hospital

1901 K Street, N. W.

Regiment

F.

HODGSON

December 6 60

Male

Canadian

3-11-32

60

Armed Forces

U.S. Marine Corps

Massachusetts

USA

Parkland Hospital

Jerry ORR

Yes

1901 K Street, N. W. Hospital Records

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14134 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>		d. STREET ADDRESS <u>4579 Arundale St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nelson</u> Middle <u>M.</u> Last <u>Hove</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-1-1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mont Co. Liquor Board</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>TORGER T. HOVE</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Curtis L. Hove (son)</u>		Address <u>PRATHER BRIDGE RD TOCCOA, GEORGIA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4-20-1</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>12-24-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>12-24-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Prairie, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14131

1. NAME OF DECEASED Toreen T. Hove		2. SEX M		3. AGE 1	
4. RACE White		5. BIRTH DATE 11-20-01		6. BIRTH PLACE Baltimore, Md.	
7. OCCUPATION None		8. MARITAL STATUS Married		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER [Signature]	
13. DATE OF DEATH 11-20-01		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF ATTENDING PHYSICIAN [Signature]	
16. SIGNATURE OF NEXT OF KIN [Signature]		17. SIGNATURE OF BURIAL OFFICIAL [Signature]		18. SIGNATURE OF REGISTRAR [Signature]	

MARY

Toreen T. Hove

Central

Mr

FATHER (brother)
Toreen, Georgia

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14135 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14067

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>05 Dickerson R.F.D.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1 Martindale Rd</u>				d. STREET ADDRESS <u>1 Martindale Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Marie Jane Hoyer</u>				4. DATE OF DEATH <u>Dec 25 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cal</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>? 1892 68</u>	
9. AGE (in years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Joseph Hoyer - Dickerson, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Jaws with generalized metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1960.0</u> (c) <u>1960.0</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				24a. REC'D BY REGISTRAR <u>Jan 4 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hirsch</u>				24c. DATE			

MEDICAL CERTIFICATION

NO. 1017
JUN 1917

(1)

(1)

RECEIVED
JUN 1917

FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

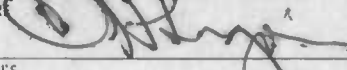
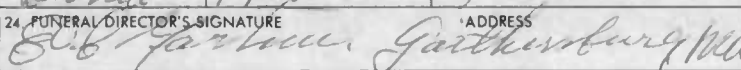
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14136 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14068

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.				d. STREET ADDRESS 5821 Bradley Blvd.			
3. NAME OF DECEASED (Type or print) Claude T Hunt				4. DATE OF DEATH Month Dec. Day 23 Year 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24 1899		9. AGE (in years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Manager		10b. KIND OF BUSINESS OR INDUSTRY Southern Railway		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles T Hunt				14. MOTHER'S MAIDEN NAME Alice May Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Elva D. Hunt-wife-same above 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 973.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blood contained ethel alcohol 0.15%, carbon monoxide 40%							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/60		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert S. Pumphrey				24a. REC'D BY REGISTRAR DATE DEC 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MONTGOMERY STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14137											
14069											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 9 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POOLESVILLE				d. STREET ADDRESS R-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First JAMES Middle HAROLD Last HURDUE			4. DATE OF DEATH Month DECEMBER Day 14 Year 19 60								
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-14-60		9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR: Months 9 Days 9 Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HAROLD DEAN HURD						14. MOTHER'S MAIDEN NAME SHIRLEY FRANCES HURD HALE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address HOSPITAL RECORDS OLNEY, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773-5 DUE TO Hyaline Membrane Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (Caesarian Sect. for Abruptio Placenta) (c) INTERVAL BETWEEN ONSET AND DEATH 9 hrs 9 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from DEC 14, 1960 to DEC 14, 1960 , that (I) (we) last saw the deceased alive on DEC 14, 1960 , and that death occurred at 02:15 AM from the causes and on the date stated above.											
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/15/60					
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.,				22d. ADDRESS SANDY SPRING, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/16/60		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or county) (State) Gaithersburg Md -					
24. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS Gaithersburg Md.		25a. REC'D BY REGISTRAR DATE DEC 19 '60		25b. REGISTRAR'S SIGNATURE Charles E. Kiano			

2073212XV2

24/11/15

Handwritten notes on the back of the letter, written upside down:

Handwritten notes on the back of the letter, written upside down:
(actual 4/10/1871 for 1871-1872)
1871-1872

15/12/20

July 10

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

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14138
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174
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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14070

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> , MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beulah 22 49h 25M</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garthburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>1 R.F.D. # 3</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Baby Girl Imes</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>27</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/26/60</i>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Imes</i>		14. MOTHER'S MAIDEN NAME <i>Rolie May Hall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>same as above</i>	
17. INFORMANT <i>John Imes father</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ATELECTASIS</i> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-26</i> 19 <i>60</i> to <i>12-27</i> 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>Dec 27 1960</i> , and that death occurred at <i>7:35</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. R. L. Snowden</i>		22b. DATE SIGNED <i>12/29/60</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-31-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>Rockville, Md</i>		DATE <i>JAN 4 '61</i>	

2074288XV5

CERTIFICATE OF BIRTH

1413

Mount Pleasant

to the date 1912

Sturbridge

Baby Girl

Times

Dec. 21

Female child

1912/10

Worcester

John Times

John Times

2126-5157

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14139											
14071											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bluesy</u> c. LENGTH OF STAY IN lb <u>1/2 hr</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Monty General Hosp</u>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Allen Claude James</u>											
4. DATE OF DEATH Month Day Year <u>Dec 27 1960</u>											
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 26-23</u> 9. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>lab</u> 11. BIRTHPLACE (State or foreign country) <u>lab</u> 12. CITIZEN OF WHAT COUNTRY? <u>lab</u>											
13. FATHER'S NAME <u>Ira James</u> 14. MOTHER'S MAIDEN NAME <u>Rosa OQUIN</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>lab</u> 16. SOCIAL SECURITY NO. <u>lab</u> 17. INFORMANT <u>Edith James (wife)</u> Address <u>lab</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic gastritis</u> 583 X DUE TO Congestion & edema of lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Chronic passive congestion, liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>lab</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>lab</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>lab</u> 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-27-60</u>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> Address (Street, city, town, or county) <u>lab</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12/30/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>lab</u> 22d. LOCATION (City, town, or country) (State) <u>lab</u>											
23. FUNERAL DIRECTOR <u>lab</u> ADDRESS <u>lab</u> 24a. REC'D BY REGISTRAR <u>lab</u> 24b. REGISTRAR'S SIGNATURE <u>lab</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

14038
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14072

1. PLACE OF DEATH a. COUNTY <u>Montgomery cty.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>29 das</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Washington Sanitarium & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Wilson</u> Last <u>James</u>		4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1864</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher -</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>America (U.S.)</u>	
13. FATHER'S NAME <u>Thomas James</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Devina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO -</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>OR Mrs. T. E. Murray</u>	
17. INFORMANT <u>112 Lee Ave Takoma Park Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO (b) <u>Senility & Cardiac Failure</u> DUE TO (c) <u>Early Viremia due to Prostatic Hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility & Early Viremia</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 22</u> 19 <u>60</u> , to <u>Dec 21</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Dec 20</u> 19 <u>60</u> , and that death occurred at <u>8:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilford D. Meyers M.D.</u> M.D.		22b. DATE SIGNED <u>Dec 21, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilford D. Meyers M.D.</u>		22d. ADDRESS <u>8323 Haddon Dr. Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 24, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Takoma Park - Tenn.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		25a. RECEIVED BY REGISTRAR <u>DEC 28 1960</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

DB

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14073

Weight 2 lbs. 14 1/4

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 07 Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital			d. STREET ADDRESS 322 Lincoln Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Joppy			4. DATE OF DEATH Month 12 Day 21 Year 19 60		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/60	9. AGE (In years lost birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Not given		14. MOTHER'S NAME Barbara Delores Joppy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 778 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bethesda	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 12/21 19 60 to 12/21 19 60 , that (I) (we) lost saw the deceased alive on 12/21 19 60 , and that death occurred at 4:35 P M, from the causes and on the date stated above.					
22a. SIGNATURE AURIN H MASERD		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) AURIN H MASERD		22d. ADDRESS 521- Wisc. Ave. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 12-27-1960	23c. NAME OF CEMETERY OR CREMATORY Suburban Hospital	23d. LOCATION (City, town, or county) (State) Bethesda, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Suburban Hospital - Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE 9 '61	25b. REGISTRAR'S SIGNATURE Charles S. Kline		

CERTIFICATE OF DEATH

141-10

141-10

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14074											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Olney</i>				c. LENGTH OF STAY IN 1b <i>1/2 hr</i>				d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X Mt Airy</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Monty Gen. Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS <i>1 R 72 # 3</i>			
3. NAME OF DECEASED (Type or print) <i>Edna Adel Justice</i>				4. DATE OF DEATH <i>Dec. 28 19 60</i>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 30 '14</i>		9. AGE (In years last birthday) <i>46 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>md</i>				11. BIRTHPLACE (State or foreign country) <i>U.S.C.</i>			
13. FATHER'S NAME <i>Reft H. Bolton</i>				14. MOTHER'S MAIDEN NAME <i>Susan Magruder</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-09-0932</i>				17. INFORMANT <i>Raymond Justice - Son 2</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>970.2</i> DUE TO <i>Barbiturate poisoning</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>970.2</i> DUE TO <i>Barbiturate poisoning</i> (c) <i>Barbiturate poisoning</i>				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank J. Broschert</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <i>12-29-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>Dec. 31, 1960</i>				22c. NAME OF CEMETERY OR CREMATORY <i>Montgomery Meth.</i>			
22d. LOCATION (City, town, or country) (State) <i>Glacettville, Md.</i>				23. FUNERAL DIRECTOR <i>Oliver L. N. [illegible]</i> ADDRESS <i>Damascus, Md.</i>							
24a. REC'D BY REGISTRAR <i>JAN 4 '61</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur S. [illegible]</i>							

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14142

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

14075

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 77 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESMOR Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last NEILIE VERONICA KEATING				4. DATE OF DEATH Month Day Year DEC. 19 1960			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 1893	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED (UNKNOWN)				10b. KIND OF BUSINESS OR INDUSTRY PROPERTY MANAGEMENT			
11. BIRTHPLACE (State or foreign country) NEW YORK				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME PATRICK KEATING				14. MOTHER'S MAIDEN NAME ELLEN REGAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NO			
17. INFORMANT EUGENE MULLIN Address (Nephew) 300 SOUTHERN Bldg., Wash. D.C.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bronchopneumonia DUE TO Cardio-vascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 months DUE TO (c) 2 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 5/14 19 57 to 12/19 19 60 , that (I) (we) lost the deceased on 12/19 19 60 , and that death occurred at 7:55 M, from the causes and on the date stated above. 22a. SIGNATURE John E. Everett M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT 22d. ADDRESS 9400 CONN. AVE., KENSINGTON 22b. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-22-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Donald DeVol ADDRESS 2224 Wisconsin Ave.				25a. REC'D BY REGISTRAR DEC 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

14115

STATE OF OHIO

14115



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14076

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Wheaton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3800 Elby Ct</u>				d. STREET ADDRESS <u>13800 Elby Ct</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George Joseph Keenan</u> First Middle Last				4. DATE OF DEATH <u>Dec 3 1960</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-30-1919</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo Keenan</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Kliney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes WWII</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Mary Keenan (wife)</u> Address <u>Ilion 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subacute Bronchitis - 3 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-9-60</u>				22b. DATE THEREOF <u>St. Peter's</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Haverstraw N.Y.</u>	
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas B Shanley</u> ADDRESS <u>3831- 94 Ave. NW.</u>				24a. REC'D BY REGISTRAR <u>DEC 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1-1-18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]

TO ASSISTANT DIRECTOR
STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14039

CERTIFICATE OF DEATH

14077

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>8 hours</u>				d. STREET ADDRESS <u>17301 Trescott Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sterling Burgess Kendig</u>				4. DATE OF DEATH <u>12</u> <u>20</u> <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-20-00</u>	
9. AGE (In years, last birth day) <u>59</u> <u>60</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railway Express Agency</u>		11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel B. Kendig</u>				14. MOTHER'S MAIDEN NAME <u>Edna L. Foose</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>714-07-8749</u>		17. INFORMANT <u>Wife</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congest Heart Failure - Acute</u>							
(b) <u>Bilateral Lobar Pneumonia</u>							
(c) <u>Dehydration Cirrhosis of Liver Chronic Alcoholism</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> , <u>1960</u> , to <u>12-20</u> , <u>1960</u> , that (I) (we) last saw the deceased alive on <u>12-20</u> , <u>1960</u> , and that death occurred at <u>5:29 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Stuart L. Nelson</u>				22b. DATE SIGNED <u>12-21-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>STUART L. NELSON</u>				22d. ADDRESS <u>7600 Carroll Ave., Takoma Park, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/24/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Giska</u>				25a. REC'D BY REGISTRAR <u>DEC 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. F...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14039

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabs on papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14144

CERTIFICATE OF DEATH

Reg. Dist. No.

14078

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>Rural-Beallsville</u>	
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>A.</u> Last <u>KIDWELL</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1907</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Park & Planning</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ernest A. Kidwell</u>		14. MOTHER'S MAIDEN NAME <u>Katie Hart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-18-2080</u>	
17. INFORMANT <u>Dollie Rosalie Kidwell-Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral Vascular Catastrophe</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-25</u> , 19 <u>60</u> , to <u>12-31</u> , 19 <u>60</u> . That I last saw the deceased alive on <u>12-30</u> , 19 <u>60</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Rogers</u>		DATE SIGNED <u>112 Shaw Ave. Silver Spring, Md. 12-31-60</u>	
PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>		<u>-112 Shaw Ave., Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/4/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Flint Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Oakton Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		24a. REC'D BY REGISTRAR <u>JAN 4 '61</u>	
ADDRESS <u>1331 E Montg. Ave. Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14145 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14079

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>Seven Locks Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Emma</u> First <u>Kinslow</u> Middle Last			4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>19 60</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16 1897</u>		9. AGE (in years last birthday) <u>63</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housemaid</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13. FATHER'S NAME <u>Robert Jones</u>			14. MOTHER'S MAIDEN NAME <u>Emma Vaskevillie</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edward Jones (brother)</u> Address <u>6440 Cabin John Rd.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Hyperkalemic Myocarditis & encephalopathy</u> DUE TO (b) <u>Arterioloneprosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetis</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>12 hrs</u> <u>??</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Cabin John</u>		(County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/5/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moses Cemetery.</u>	
22d. LOCATION (City, town, or county) <u>Cabin John, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

1503

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

NAME OF DECEASED [REDACTED]		AGE [REDACTED]		SEX [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CITY [REDACTED]		COUNTY [REDACTED]	
OCCUPATION [REDACTED]		EDUCATION [REDACTED]		MARRIAGE [REDACTED]		RELIGION [REDACTED]	
PREVIOUS ILLNESS [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL OPINION [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF SECOND WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF THIRD WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF FOURTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF FIFTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF SIXTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF SEVENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF EIGHTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF NINTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF TENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF ELEVENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF TWELFTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF THIRTEENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF FOURTEENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF FIFTEENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF SIXTEENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF SEVENTEENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF EIGHTEENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF NINETEENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF TWENTIETH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH

RECEIVED BY THE STATE DEPARTMENT OF HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14040
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>7015 Sycamore Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>Lakoma Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Buffington Kissinger</u>		First Middle Last		4. DATE OF DEATH <u>12 13 1960</u>		Month Day Year	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-9-86</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not Available?</u>				14. MOTHER'S MAIDEN NAME <u>Not Available</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>10-W-1</u>		16. SOCIAL SECURITY NO. <u>10-W-1</u>		17. INFORMANT <u>Lewis Harrison, 502 Dartmouth Ave. S.S. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>History of previous heart disease</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-13-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 16, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Selinsgrove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Selinsgrove, Snyder Co. Pa.</u>	
23. FUNERAL DIRECTOR <u>Arthur Walters - 234 Carroll St. N.W. - Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>DEC 1 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

U.S. DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D.C. 20501

12-11-55

1

12-11-55

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>1 day</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William Hamilton Knox</i>				4. DATE OF DEATH <i>Dec 11 1960</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-22-97</i>	
9. AGE (In years lost birthday) <i>63 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Maritime Comm. statistician</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>statistician</i>			
13. FATHER'S NAME <i>William S. Knox</i>				14. MOTHER'S MAIDEN NAME <i>Cora Hamilton</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>1917</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>wife - Jane Knox - same 2d</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> 420.1 DUE TO <i>Myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Coronary Atherosclerosis</i> DUE TO (c) <i>diabetes mellitus - Cirrhosis of liver, Bladder, esophagus, Spleen</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>24-36 hours</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>NONE</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <i>1955</i> to <i>Dec 11 1960</i> , that (I) <i>(me)</i> last saw the deceased alive on <i>Dec 11 1960</i> , and that death occurred at <i>7:35</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Stephen C. Cromwell</i> M.D.				22b. DATE SIGNED <i>12/11/60</i>		22c. PHYSICIAN'S NAME (Type) <i>Stephen C. Cromwell</i>	
22d. ADDRESS <i>Rockville, Md.</i>				23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>			
23b. DATE THEREOF <i>12/14/60</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				25a. REC'D BY REGISTRAR <i>DEC 15 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Robert S. Kraus</i>	

EXTRACTS FOR DEATH

1-11-18

George A. Robinson, Baltimore, Maryland
Oscar Hill, Secretary, Baltimore, Maryland
Stephen E. Brownell

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14147

14082

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 84 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS Route # 3, Box 66	
3. NAME OF DECEASED (Type or print) First Eugene Middle Carl Last Koeln		4. DATE OF DEATH Month December Day 21 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1931
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min. 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Koeln		14. MOTHER'S MAIDEN NAME Alma Jundt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 400-30-7116	
17. INFORMANT The Medical Record, Address		17. INFORMANT The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombocytopenia DUE TO (c) Acute myelogenous leukemia		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 2 months 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (u) (this hospital) attended the deceased from September 28, 1960 , to December 21, 1960 , that (u) (we) lost the deceased alive on Dec. 21, 1960 , and that death occurred at 9:05 AM from the causes and on the date stated above.			
22a. SIGNATURE Edward E. Morse		22b. DATE SIGNED 12/21/60	
22c. PHYSICIAN'S NAME (Type) Edward E. Morse, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 12/22/60		23b. DATE THEREOF 12/22/60	
23c. NAME OF CEMETERY OR CREMATORY St. Louis, Missouri		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24. ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR DEC 27 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hance	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Race

5. Date of birth

6. Place of birth

7. Date of death

8. Place of death

9. Cause of death

10. Manner of death

11. Signature of physician

12. Date of report

13. Signature of registrar

14. Signature of coroner

15. Signature of medical examiner

16. Signature of health officer

17. Signature of clerk

18. Signature of nurse

19. Signature of undertaker

20. Signature of funeral home

21. Signature of cemetery

22. Signature of burial society

23. Signature of church

24. Signature of family

25. Signature of friends

26. Signature of neighbors

27. Signature of community

28. Signature of school

29. Signature of business

30. Signature of government

31. Signature of industry

32. Signature of labor

33. Signature of capital

34. Signature of science

35. Signature of art

36. Signature of religion

37. Signature of philosophy

38. Signature of history

39. Signature of geography

39. Signature of history

40. Signature of geography

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14041

14083

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 24 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Esther First K. Middle Kuhn Last		4. DATE OF DEATH Month December Day 5 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-97
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry P. Jenkins		14. MOTHER'S MAIDEN NAME Blanche Coates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Admitting Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-20 1960 to 5-6-60 , that (I) (we) last saw the deceased alive on 12-5 1960 , and that death occurred at 1:18P from the causes and on the date stated above.			
22a. SIGNATURE D. R. Purdie		22b. DATE SIGNED 12-6-60	
22c. PHYSICIAN'S NAME (Type) D. R. Purdie, M. D.		22d. ADDRESS 4404 Queensbury Road, Riverdale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 8, 1960	
23c. NAME OF CEMETERY OR INTERMENT PLACE National Memorial Park		23d. LOCATION (City, town, or county) (State) Falls Church Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24b. REGISTRAR'S SIGNATURE DEC 12 '60	
ADDRESS Hyattsville Md.		DATE	

14043

CERTIFICATE OF DEATH

14043

Blank certificate form with faint lines and text, including fields for name, date, and location.

CERTIFICATE OF DEATH

Reg. Dist. No.

14084

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4415 Rosedale Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>KUSTER</u> Last		4. DATE OF DEATH <u>December</u> Month <u>14</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/60</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>1</u> Min. <u>30</u>	11. IF UNDER 24 HRS. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES KUSTER</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE MAR WRIGHT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Charles Kuster-father-same 2d</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Extradural Hemorrhage</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/14</u> , 19 <u>60</u> , to <u>12/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/14/60</u> , 19 <u>60</u> , and that death occurred at <u>11:20</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo E. Donohue M.D.</u>		ADDRESS (Street, city or town, state) <u>8218 Wisc Ave</u> DATE SIGNED <u>12/14/60</u>	
PHYSICIAN'S NAME (Type) <u>Leo E. Donohue M.D.</u>		<u>Bethesda Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Bumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	
DATE <u>DEC 20 '60</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14149

14085

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 46 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5601 Huntington Parkway				d. STREET ADDRESS 5601 Huntington Parkway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Bergliott Middle Last Larsen				4. DATE OF DEATH Month December Day 18 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1883	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 5 Days 29		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? U.S. Natural ized							
13. FATHER'S NAME Theadore Dahl				14. MOTHER'S MAIDEN NAME Bergitte Stromsted			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Von der Fehr-daughter-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Acute Cardiac failure DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-2-58 to 12-18-60 that (I) was lost saw the deceased alive on 12-13-1960 and that death occurred 11:05 M, from the causes and on the date stated above.							
22a. SIGNATURE C. Roger Kurtz		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-18-60	
22c. PHYSICIAN'S NAME (Type) C. Roger Kurtz, M.D.		22d. ADDRESS 3701 Conn. Ave. N.W., Wash. 8, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit 12/21/60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Ocean View Cemetery		23d. LOCATION (City, town, or county) (State) Staten Island, New York	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 21 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Knaus			

CERTIFICATE OF DEATH

14140

Non-Resident of the State of New York

State of New York

County of New York

City of New York

Decedent's Name

Age

Sex

Marital Status

Place of Birth

Date of Death

Time of Death

Place of Death

Cause of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Witness

Signature of Second Witness

Signature of Third Witness

Signature of Fourth Witness

Signature of Fifth Witness

Signature of Sixth Witness

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14150

14086

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 24 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 7405 River Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Janie Middle Eudoria Last Lee				4. DATE OF DEATH Month Dec. Day 28 Year 1960			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/5/85	
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Luther Lane				14. MOTHER'S MAIDEN NAME Pocohontas Saffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Niece (Mrs. C. Pratt)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Multiple Myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Myeloma DUE TO Multiple Myeloma (c) Multiple Myeloma				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 23, 1960 to Dec. 18, 1960 , that (I) (we) last saw the deceased alive on Dec. 27, 1960 , and that death occurred at 1:53 AM , from the causes and on the date stated above.							
22a. SIGNATURE W. T. Joyce				22b. DATE SIGNED 12/28/60			
22c. PHYSICIAN'S NAME (Type) William T. Joyce, M.D.				22d. ADDRESS 8106 Maple Ridge Rd. Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/31/60		23c. NAME OF CEMETERY OR CREMATORY Clifton Cemetery		23d. LOCATION (City, town, or county) (State) Clifton, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 29 '60	
25b. REGISTRAR'S SIGNATURE Edith S. Kinner				25c. DATE DEC 29 '60			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG278 1-6-61 et

CERTIFICATE OF DEATH

Reg. Dist. No.

14087

14042

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash. D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM				d. STREET ADDRESS 2028 Nichols Ave. S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frances Middle Levy Last Levy				4. DATE OF DEATH Month Dec. Day 28 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jacob Levy				14. MOTHER'S MAIDEN NAME Minnie Levy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. Jerome Levy Address 2028-Nichols Av. S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Cerebral thrombosis & right hemiplegia DUE TO arteriosclerotic and lying cause last. Hypertensive Cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH 4 days 2 months 7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 2 , 19 60 , to Dec 28 , 19 60 , that I last saw the deceased alive on Dec 28 , 19 60 , and that death occurred at 10:30 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE H B Orleans				ADDRESS (Street, city or town, state) 9500 Colson Rd Silver Spring Md			
PHYSICIAN'S NAME (Type) H. B ORLEANS				DATE SIGNED 12/28/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Ohey Shalom-Talmud Torah Cem.		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & Sons				24a. REC'D BY REGISTRAR Wash. D.C.			
				24b. REGISTRAR'S SIGNATURE Anthony S. Thomas			

CERTIFICATE OF DEATH

14049

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Place of death
6. Cause of death
7. Signature of physician
8. Signature of registrar

9. Date of burial
10. Place of burial
11. Signature of funeral director
12. Signature of registrar

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14151

14088

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7½ hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 6223 Piney Branch Road, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Charles MacHenry LINDSAY				4. DATE OF DEATH Month Day Year December 18 19 60											
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-90		9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Mariner (Retired)				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David LINDSAY						14. MOTHER'S MAIDEN NAME Emma (unknown)									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1911 to 1945				16. SOCIAL SECURITY NO. (W) Mrs. Ethel R. Lindsay, same as #2 above				17. INFORMANT (W) Mrs. Ethel R. Lindsay, same as #2 above				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 540.0 IMMEDIATE CAUSE (a) Ulcer, Stomach NEC & Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 hrs.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe arteriosclerotic heart & Cardiovascular disease												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from Dec. 18 19 60 to Dec. 18 19 60 that (X) (we) last saw the deceased alive on Dec. 18 19 60 , and that death occurred at 11:14 PM , from the causes and on the date stated above.															
22a. SIGNATURE W. D. HOOVER				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 12-19-60							
22c. PHYSICIAN'S NAME (Type) W. D. HOOVER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-22-60				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) Arlington Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE S.H. HINES				ADDRESS 2901 14th St., Washington, D. C.				25a. REC'D BY REGISTRAR DEC 23 '60				25b. REGISTRAR'S SIGNATURE Orlino S. Hines			

1458

CENTRAL AVENUE OF CHAIR

1411

Department of Columbia

Department

Washington

Department (H&M)

6325 Prince Street Road, N.W.

U. S. Naval Hospital

LAND Y

Washington

Charles

Department 12

4-7-50

Continental

Male

U.S.A.

New York

U. S. Navy

Mariner (H&M)

Area (unknown)

David LINDSEY

(W) Mrs. Rachel R. Lindsey, born 10-10-1911

Yes 1911 to 1947

Dec. 18 1947

Dec. 18 1947

12-19-50

U. S. Naval Hospital, Bethesda, Md.

W. D. Roper, M.D., M.P.H.

Virginia

Washington

Washington National

Bureau

U. S. Naval Hospital, Bethesda, D. C.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

14152
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14089

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b /19hrs. 25min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		d. STREET ADDRESS 13X-2	
3. NAME OF DECEASED (Type or print) First Agnes Middle Louise Last Linthicum		4. DATE OF DEATH Month December Day 18 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 18 1930
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Howard		14. MOTHER'S MAIDEN NAME Susie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas H. Linthicum, Dayton, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Cardiac failure DUE TO (c) Bronchial pneumonia		INTERVAL BETWEEN ONSET AND DEATH 36 hours 36 hours 36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19 50 to December 18 60 that (I) (we) last saw the deceased alive on Dec. 17 19 60 , and that death occurred at 6:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles Whitaker, M.D.		22d. ADDRESS Clarksville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-20-60	
23c. NAME OF CEMETERY OR CREMATORY Providence		23d. LOCATION (City, town, or county) (State) Glenelg, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR DATE DEC 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1915

DATE OF BIRTH: 1915

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF INTERMENT: [illegible]

PLACE OF INTERMENT: [illegible]

DATE OF BURIAL: [illegible]

DATE OF CREMATION: [illegible]

DATE OF EXHUMATION: [illegible]

DATE OF REINTERMENT: [illegible]

DATE OF RECORDING: [illegible]

DATE OF INDEXING: [illegible]

DATE OF FILING: [illegible]

DATE OF DEPOSIT: [illegible]

DATE OF REMOVAL: [illegible]

DATE OF RETURN: [illegible]

DATE OF RECOVERY: [illegible]

DATE OF REUSE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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14153

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14090

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1hr. 45 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Annandale e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Delbert Warren LYNCH		4. DATE OF DEATH Month Day Year December 11 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-60
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins. 1 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Don Leon LYNCH		14. MOTHER'S MAIDEN NAME Violet June THOMPSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Don L. Lynch, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 7 7 6 X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 11, 1960 to Dec. 11, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 11, 1960 , and that death occurred at 6:05 AM , from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Grello		22b. DATE SIGNED 12-11-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-13-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		25a. REC'D BY REGISTRAR DEC 13 '60	
ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kirsch	

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by the attending physician and completely filled in by the funeral director,
The above remove carbon remove. Please I need to should be cited.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14154

14091

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 55 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mexico b. COUNTY Mexico City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mexico City d. STREET ADDRESS Uruguayan Embassy e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Dulcia Pereira MAC EACHEN			4. DATE OF DEATH Month Day Year December 11 1960				
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-29-08	9. AGE (In years lost birthday) yrs. 52	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Uruguay			
12. CITIZEN OF WHAT COUNTRY? Uruguay			13. FATHER'S NAME Jose Maria Pereira y Rocha				
14. MOTHER'S MAIDEN NAME Dulcia CORTINAS			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. None			17. INFORMANT Address (H) R.E. MacEachen, Uruguayan Embassy, London, England				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoblastic Lymphosarcoma DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.					INTERVAL BETWEEN ONSET AND DEATH 8 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 17 1960 to Dec. 11 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 11 1960 , and that death occurred at 9:50PM , from the causes and on the date stated above.							
22a. SIGNATURE F. H. O'Connell		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 12-12-60				
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment	23b. DATE THEREOF 12-13-60	23c. NAME OF CEMETERY OR CREMATORY R. A. Pumphrey Funeral Home, Bethesda, Md.	23d. LOCATION (City, town, or county) (State) Mexico City Mexico	25a. REC'D IN REGISTRAR'S OFFICE DATE DEC 13 '60			
24. REGISTRAR'S SIGNATURE R. A. Pumphrey		25b. REGISTRAR'S SIGNATURE Arthur S. Evans					

TO HOSPITAL ATTENDING PHYSICIAN: This certificate may be retained by the hospital. TO FUNERAL DIRECTOR: After page 3 should be detached for use as the burial, cremation, or removal, or removal, and in any event, within 72 hours after death. the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

U.S. DEPARTMENT OF COMMERCE

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U. S. Naval Hospital, Bethesda, Md.

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(H) A. E. Nicholson, Birmingham University, London, England

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14092

14155

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MONTGOMERY MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. STREET ADDRESS 1109 EDMONSTON DR.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN S. MAC SPORRAN				4. DATE OF DEATH Month Day Year 12/30/60 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/18		9. AGE (In years lost birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Managerment		10b. KIND OF BUSINESS OR INDUSTRY Consultant		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN A. MAC SPORRAN				14. MOTHER'S MAIDEN NAME ELIZABETH MACFARLANE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. ARMY WW II 045-03-6465		17. INFORMANT Mrs. Susanna C. MacSporran WIFE (SAME AS ABOVE)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Confluent bronchopneumonia, bilateral DUE TO Pneumococcus Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). Massive Fatty Metamorphosis liver						INTERVAL BETWEEN ONSET AND DEATH ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954 to Dec. 30, 1960 that (I) (we) last saw the deceased alive on Dec. 30, 60 , and that death occurred at 12:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Charles Savarese MD				22b. ADDRESS 4890 Battery Lane, Bethesda, Md.		22c. PHYSICIAN'S NAME (Type) CHARLES SAVARESE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-31-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Prince George County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR DATE JAN 3 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

14043

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14093

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nell</u> Middle <u>none</u> Last <u>Manda</u>		4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-5-84</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>	11. IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>< Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>James Martin Hysong</u>		14. MOTHER'S MAIDEN NAME <u>Ma Anna Gross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mary O. Hysong; 1300 N. St., N.W. Wash. D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Emotive heart failure; heart shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ac myocardial infarction post mortem</u> (c) <u>probably old heart infarction</u> <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>12 yrs</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>12/18/1960</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/18/1960</u> to <u>12/24/1960</u> that (I) (we) last saw the deceased alive on <u>12/24/1960</u> and that death occurred at <u>11:15 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas H Wolohin</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohin</u>		22d. ADDRESS <u>7600 Carroll Ave, Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/27/1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Blacksburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hysong Funeral Home</u>		25. RECEIVED BY REGISTRAR <u>DEC 27 '60</u>	
ADDRESS <u>1300 N St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

CERTIFICATE OF DEATH

14013

John J. ...

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Washington, D.C.

June 10, 1913

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Retired

June 10, 1913

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

14156

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE HARLIN MARKLEY		4. DATE OF DEATH Month Day Year 12/10/60 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/06
9. AGE (In years lost birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Research	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Simon MARKLEY	
14. MOTHER'S MAIDEN NAME Myrtle Harris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT WIFE(SAME AS ABOVE) Margaret Markley Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 days 5 day Indef			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1960 to 12/10, 1960 , that I last saw the deceased alive on 12/10/60 , 19 60 , and that death occurred at 12:35 P.M. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 809 Viers Mill Rd. Rockville Md. DATE SIGNED 12/10/60			
ACTUAL SIGNATURE Stephen N. Jones M.D.		PHYSICIAN'S NAME (Type) STEPHEN N. JONES	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/60	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 15 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours, after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14044

14095

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, md. 15</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				d. STREET ADDRESS <u>RFD #2, 12921 Columbia Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>THOMAS CLARK MARLOW</u>				4. DATE OF DEATH <u>December 12 1960</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-14-81</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (retired)</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pinkney marlow</u>				14. MOTHER'S MAIDEN NAME <u>Emma Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible shock</u> <u>561.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal obstruction</u> (c) <u>Strangulated Rt. Inguinal hernia</u> <u>Gangrene terminal ileum & perforation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes & senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days?</u> <u>hca.?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-12-1960</u> to <u>12-12-1960</u> , that (I) (we) last saw the deceased alive on <u>12-12-1960</u> , and that death occurred at <u>7:57 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul V. Starr</u>				22b. DATE SIGNED <u>Dec. 13-1960</u>		22c. PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>	
22d. ADDRESS <u>7600 Carroll Ave. Takoma Park, Md.</u>				22e. REC'D BY REGISTRAR <u>DEC 19 '60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/16/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Catholic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pimphrey, Inc.</u>				24b. REGISTRAR'S SIGNATURE <u>William S. Thrall</u>		24c. REGISTRAR'S NAME (Type) <u>William S. Thrall</u>	

CERTIFICATE OF DEATH

1-10-11

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of Registrar
9. Signature of Medical Officer
10. Signature of Coroner

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14157

CERTIFICATE OF DEATH

Reg. Dist. No. 14096

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. STREET ADDRESS <u>R. D. #4</u>			
3. NAME OF DECEASED (Type or print) First <u>Steven</u> Middle <u>Gene</u> Last <u>Marshall</u>				4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 23, 1960</u>	
9. AGE (In years last birthday) yrs. <u>9</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William G. Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Mary N. Avant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> DUE TO <u>atelectasis and pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malignant sarcoma</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>weeks</u> <u>months</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>December 20, 1960</u> , to <u>December 25, 1960</u> , that I last saw the deceased alive on <u>December 25, 1960</u> , and that death occurred at <u>5:35 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jerome B. Black</u>				DATE SIGNED <u>12/26/60</u>			
PHYSICIAN'S NAME (Type) <u>Jerome B. Black M.D.</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salmon Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dover Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

202. 1. 202

2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 26, 28, 30, 32, 34, 36, 38, 40, 42, 44, 46, 48, 50, 52, 54, 56, 58, 60, 62, 64, 66, 68, 70, 72, 74, 76, 78, 80, 82, 84, 86, 88, 90, 92, 94, 96, 98, 100

15-53-51

2-2-21

5-53-62

2nd 8. 100

לרבותם ואלה

25159

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14159

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14098

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN FRANKLIN MASON				4. DATE OF DEATH Month Day Year Dec. 18, 1960			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 10, 1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John F. Mason				14. MOTHER'S MAIDEN NAME Harriet Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mildred Stewart Address Germantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1958 to Dec 18, 1960 , that (I) (we) lost saw the deceased alive on Dec 17, 1960 , and that death occurred AM from the causes and on the date stated above.							
22a. SIGNATURE Vernon E. Marten M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 20 - 60	
22c. PHYSICIAN'S NAME (Type) Vernon E. Marten				22d. ADDRESS Germantown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/60		23c. NAME OF CEMETERY OR CREMATORY Brownstown.		23d. LOCATION (City, town, or county) (State) Germantown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Shroder ADDRESS Rockville, Md.				25a. REC'D BY REGISTRAR DATE JAN 3 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Haines	

CERTIFICATE OF DEATH

1-1-19

CHILDREN

John J. Keenan
John J. Keenan

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
14160
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14099

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		MARYLAND c. LENGTH OF STAY IN 1b 15 min.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Washington 19 d. STREET ADDRESS 304 Anacostia Road - Apt. 302		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl,		First MATHIAS		Last December 5		4. DATE OF DEATH Month 19 60	
5. SEX Female		6. COLOR OR RACE Mongolian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-60	
9. AGE (In years lost birthday) 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Garrett V. MATHIAS		14. MOTHER'S MAIDEN NAME Sumiko HATANO		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Garrett V. Mathias, same as #2 above		Address #2 above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity (appr. 18 weeks gestation) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) deceased attended the deceased from Dec. 5 19 60 to Dec. 5 19 60 , that (I) was last saw the deceased alive on Dec. 5 19 60 , and that death occurred at 5A M, from the causes and on the date stated above.		22a. SIGNATURE <i>A. O. Anctil, Jr.</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12-5-60	
22c. PHYSICIAN'S NAME (Type) A. O. ANCTIL, JR., LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) Arlington Virginia		24. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i> R. A. PUMPHREY FUNERAL HOME, BETHESDA, MD.		25a. REC'D BY REGISTRAR DATE DEC 7 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hester</i>		25c. REGISTRAR'S SIGNATURE <i>Arthur L. Hester</i>		25d. REGISTRAR'S SIGNATURE <i>Arthur L. Hester</i>		25e. REGISTRAR'S SIGNATURE <i>Arthur L. Hester</i>	

Director of Columbia

Washington 19

304 Annapolis Road - Apt. 302

MATHEIAS

December 3

12-3-50

Maryland

U.S.A.

Genito V. MATHEIAS

Genito V. MATHEIAS

(V) Genito V. Matheias, born as above

Name

No

Immaturity (approx. 18 weeks gestation)

Dec. 2 1950

2A

60

12-3-50

A. O. ANTONIO, JR., MD, GEN. U. S. Naval Hospital, Bethesda, MD.

Washington

12-7-50

Genito

R. A. FREEMAN, M.D., WASHINGTON, MD.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14045

CERTIFICATE OF DEATH

14100

Items 13, 14, 21 Film 6279 1-18-61 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>California</u> b. COUNTY <u>SAN MATEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>35 mins</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitar</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>D.</u> Middle <u>Clark</u> Last <u>Matthews</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-10</u>
9. AGE (In years lost birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vitro Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Sackson, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>D. Stanley Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>366-10-3287</u>	
17. INFORMANT <u>John R. Martineau SS. Md.</u>		Address <u>14000 George Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>2 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3:30 PM Dec 15, 1960</u> to <u>3:05 PM Dec 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 15, 1960</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond O. West</u>		22b. DATE SIGNED <u>12/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>		22d. ADDRESS <u>% Washington Sanitarium & Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 19, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Uppeland; Washburn; Mich.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., Silver Spring Md.</u>		25a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		25c. DATE <u>DEC 19 '60</u>	

7402

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14046

CERTIFICATE OF DEATH

Reg. Dist. No.

14101

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> (12)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cedar Haven Rest Home</i>		d. STREET ADDRESS <i>613 Philadelphia Ave. 171309</i>	
3. NAME OF DECEASED (Type or print) First <i>Minnie</i> Middle <i>McCurdy</i> Last <i>McCurdy</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>23</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 13 1895</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	9. AGE (In years last birthday) <i>65</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Charlotte NC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Abernathy</i>		14. MOTHER'S MAIDEN NAME <i>Jane Abernathy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Andrew W. Alexander</i>		Address <i>3253 Slightman St. Wash D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pneumonia</i> DUE TO <i>49.3</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Senility</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1, 1960</i> , to <i>Dec 23, 1960</i> , that I last saw the deceased alive on <i>Dec 23, 1960</i> , and that death occurred at <i>12:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip E. Jones</i> M.D.		ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive Silver Spring Md</i>	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>			
22a. BURIAL, CREMATION, OR REMOVAL PERMIT <input checked="" type="checkbox"/>	22b. DATE THEREOF <i>12-23-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm. Lee's Sons Co.</i>		ADDRESS <i>300-4th Street N.E.</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 28 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

14040

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1914	
NAME OF DECEASED [illegible]		SEX [illegible]	
AGE [illegible]		OCCUPATION [illegible]	
PLACE OF BIRTH [illegible]		PLACE OF DEATH [illegible]	
CAUSE OF DEATH [illegible]		MANNER OF DEATH [illegible]	
TIME OF DEATH [illegible]		PLACE OF BURIAL [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF REGISTRAR [illegible]	
CERTIFICATE OF DEATH [illegible]		[illegible]	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner, or by the registrar, or by the undertaker, or by the person who has taken charge of the funeral. It is to be filled out in duplicate, one copy to be retained by the registrar, and the other copy to be sent to the State Department of Health, Baltimore, Maryland.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
14012

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14102

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>years</u> <u>22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>220 Granville Drive</u>				d. STREET ADDRESS <u>220 Granville Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>NELL</u> Middle <u>A.</u> Last <u>McGEEVER</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8, 1909</u>	
9. AGE (In years lost birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u> Hours <u>13</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>13</u> Hours <u>13</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Larned, Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Not Available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>John J. McGeever, (same as #2)</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Ovary with metastasis</u> 175.0 DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>12 Dec 1960</u> to <u>13 Dec 1960</u> , that (I) (we) last saw the deceased alive on <u>12 Dec 1960</u> and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Auld</u>				22b. DATE SIGNED <u>13 Dec 60</u>		22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D. AULD</u>	
22d. ADDRESS <u>9006 Coleville Rd. Silver Spring Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec. 16, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>DEC 16 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

14013

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14161

Item 1 film G279 1-12-61 et

14103

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beyhesda		c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Pa. b. COUNTY Pittsburgh 32		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh 32		d. STREET ADDRESS 5440 5th Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dorothy McMurry		First Dorothy		Middle McMurry		Last Dorothy		4. DATE OF DEATH Dec. 30		Month Dec.		Day 30		Year 19 60	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7 1896		9. AGE (in years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Univ. of Pittsburg		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A									
13. FATHER'S NAME Chas. A. McMurry		14. MOTHER'S MAIDEN NAME Emily Le Crone		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Donald McMurry		Address 514 - Warren Rd. Ithaca, N.Y.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injury Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 816 X DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Driver of car which ran in rear of truck		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran in rear of truck		20c. TIME OF INJURY Month, Day, Year 12/30/60 9:10 PM 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) Bethesda		(County) Montg. Md.		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/31/60							
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) Frank J. Broschart		22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Jan. 2, 1961		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or country) Prince George Co., Md.		23. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR JAN 5 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus													

17115

52. 2003.05.15

ADJ

US Route 205 Old Georgetown Rd.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14174

1. PLACE OF DEATH a. COUNTY		2. Film G-279 1-23/61.		3. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		b. COUNTY	
Montgomery		MARYLAND		Pa.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
Bethesda		DOA		Pittsburgh 32 Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Suburban Hospital US Route 240 & Old Georgetown Rd.				5440 5th Ave		1830 K St., N.W.	
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
Ruth E. McMurry				12/30/60		19	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
female		white				13 5/12/92	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
International Education				Illinois		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Charles A. McMurry		Emilie Le Crone					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no				brother Donald L. McMurry		1514 Wagon Rd. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries 8 16x DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car which ran in rear of truck					
20c. TIME OF INJURY Hour 9:10 p.m. 12/30/60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) (County) (State) Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
Frank J. Broschart		Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12/31/60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Cremations		Jan. 2, 1961		Cedar Hill Crematory		Prince George Co., Md.	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY		Bethesda, Md.		DATE JAN 5 '61		Arthur S. Hume	

RECEIVED
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Montgomery

Residence

Age

Pillsbury 32

US House No 20 & Old Georgetown Rd.

Birth E. Kentucky

12/3/00

Female

White

5' 8" 125

65

Person in car when ran in rear of truck

12/12/00

0:10

Highway

X

Bartholomew County, Mo.

X

12/11/00

State of Kentucky

Testimony of J. H. Smith, Jr. Sheriff of Bartholomew County, Mo.

Subscribed and sworn to before me this 12th day of December, 1900.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14047

14105

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. SAN & Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Edward Melton</u>		4. DATE OF DEATH <u>12 11 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>ROBERT EDWARD MELTON</u>		14. MOTHER'S MAIDEN NAME <u>NANNIE PIERCE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>YES</u> <u>WW #1</u>		16. SOCIAL SECURITY NO. <u>217-32-0737</u>	
17. INFORMANT <u>Mrs. Neva G. Melton, 2906 Weller Rd.</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 June 1959</u> to <u>11 Dec 1960</u> that (I) (we) lost saw the deceased alive on <u>28 Nov 1960</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas P. Fogarty</u> M.D.		22b. DATE SIGNED <u>11 Dec 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS P. FOGARTY</u>		22d. ADDRESS <u>1011 Univ. Blvd E. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/14/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pomeroy, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1901

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Signature of informant

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14163

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14106

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 48	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4857 Battery Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4857 Battery Lane, Apt. 303		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH M MICHELSON		4. DATE OF DEATH Month Day Year Dec. 31, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 17, 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Conductor		12. KIND OF BUSINESS OR INDUSTRY - Retired	
13. BIRTHPLACE (State or foreign country) Chicago, Illinois		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME Oscar Michelson		16. MOTHER'S MAIDEN NAME Unknown	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. 337-03-4064	
19. INFORMANT Son		20. ADDRESS 5205 Gretchen St. Kensington, Md.	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 hours 5 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric hemorrhage, cause undetermined		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 1960 , to December 31, 1960 , that (I) did last saw the deceased alive on Dec. 31, 1960 , and that death occurred at 12:55 M, from the causes and on the date stated above.		22a. SIGNATURE Robert G. Angle M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.		22d. ADDRESS 5009 Del Ray Avenue, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 1-2-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR JAN 5 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Klaus	

14163

CERTIFICATE OF DEATH

HOME COUNTY

as in and

LAST NAME FIRST NAME

DECEASED

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14164

CERTIFICATE OF DEATH

Reg. Dist. No.

14107

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quince Orchard-Rural				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D.# 3 Gaithersburg				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle AGNES Last MILLS				4. DATE OF DEATH Month December Day 18 Year 1960			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1876	9. AGE (In years last birthday) yrs. 84	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George Ward				14. MOTHER'S MAIDEN NAME Josephine Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		INFORMANT Reuben J. Mills-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) congestive heart failure DUE TO (c) Hypertensive cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ventral hernia, obesity						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from May , 19 50 , to Dec 18 , 19 60 , that I last saw the deceased alive on Dec 16 , 19 60 , and that death occurred 6:45A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DAWSONVILLE DATE SIGNED Dec. 18, 1960 ACTUAL SIGNATURE John G. Fawcett M.D. P.O. Boyd, Md. PHYSICIAN'S NAME (Type) JOHN G. FAWCETT M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/60		22c. NAME OF CEMETERY OR CREMATORY Darnestown Ch. Cem.		22d. LOCATION (City, town, or county) (State) Darnestown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home 1321 E. Monte Ave., Rockville, Md.				24a. REC'D BY REGISTRAR DATE DEC 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14184

WILLIS E. THOMAS, JR.

Residing at
Bridge Street, Baltimore, Md.
Thyroid gland carcinoma
General Health - Poor

Dec 15 1950
John G. Fawcett
John G. Fawcett MD
Pc Boyd, Md.
Dawsonville
Dec 15, 1950

CERTIFICATE OF DEATH

Reg. Dist. No.

14108

14013

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 4 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12033 BERRY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle I Last MILLS		4. DATE OF DEATH Month 12- Day 28- Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-96
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 15 Min.	11. IF UNDER 24 HRS. Months 6 Days 4 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ADDIS KRUSEN		14. MOTHER'S MAIDEN NAME MAUDE I. HUGHES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-56-6991	
17. INFORMANT GEORGE P. MILLS, JR.		Address SAME AS #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Carcinoma Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 6 months DUE TO Melanomas Brain & Lungs 3 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 11, 1960 to Dec 29, 1960 that I lost saw the deceased alive on Dec 29, 1960 , and that death occurred at 1:14 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John J. Curry		DATE SIGNED 10620 Georgia Ave 12/29/60	
PHYSICIAN'S NAME (Type) JOHN J. CURRY		Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-31-60	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY SILVER SPRING MARYLAND		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		24a. REC'D BY REGISTRAR DEC 30 '60	
ADDRESS WASH. D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. House	
25. FUNERAL DIRECTOR'S NAME FRANCIS J. COLLINS		26. ADDRESS 3821 14TH. ST. N.W.	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14013

14102

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14165

14109

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pi. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 35 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle Anastasia Last MOHL				4. DATE OF DEATH Month December Day 16 Year 19 60			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-8-1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71	IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min. 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife & Mother		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James HOEY				14. MOTHER'S MAIDEN NAME Margaret MC CAFFREY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 087-16-9029		17. INFORMANT Address (S) Capt. E. V. Mohl, USN, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, descending colon, with widespread metastases. DUE TO (b) 153-2 Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause last. (c) 153-2						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 12, 19 60 to Dec. 16, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 16 19 60 , and that death occurred at 12:35 PM , from the causes and on the date stated above.							
22a. SIGNATURE R. G. Muth				22b. DATE SIGNED 12-16-60		22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22e. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 12/19/60		23c. NAME OF CEMETERY OR CREMATORY Holy Name Cemetery		23d. LOCATION (City, town, or county) (State) Jersey City New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc				25a. REC'D BY REGISTRAR DEC 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hana	

CERTIFICATE OF DEATH

14163

Name: James Henry
 Sex: Male
 Race: Caucasian
 Date of Birth: 10-8-1893
 Place of Birth: New Jersey
 Date of Death: December 10, 1960
 Place of Death: U. S. Naval Hospital, Bethesda, Md.
 Cause of Death: Myocardial Infarction
 Physician: Dr. J. H. Smith
 Burial Place: New Jersey
 Signature: [Signature]
 Date: 12-10-60

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14048

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14110

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>		c. LENGTH OF STAY IN 1b <u>12 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium + Hospital.</u>		d. STREET ADDRESS <u>1606 Bonifant St.</u>	
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>O'DEAN</u> Last <u>MONTGOMERY</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29, 1921</u>
9. AGE (In years lost birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Minnesota.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Frank C. Montgomery</u>		14. MOTHER'S MAIDEN NAME <u>Helen Kinsella</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes - 1 WWII</u>		16. SOCIAL SECURITY NO. <u>523-07-5547</u>	
17. INFORMANT <u>Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Antero-septal myocardial infarction</u> DUE TO <u>Arteriosclerotic cardiovascular-renal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 d.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 2</u> 19 <u>60</u> to <u>Dec 14</u> 19 <u>60</u> that <u>it (we)</u> last saw the deceased alive on <u>Dec 14</u> 19 <u>60</u> , and that death occurred at <u>10:04</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William F. Simpson, Jr.</u> M.D.		22b. DATE SIGNED <u>12/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>William F. Simpson Jr.</u>		22d. ADDRESS <u>6216 N.H. Ave. N.E. - D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 19, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc. Silver Spring, MD.</u> <u>Raymond A. Ziska</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 22 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Clara S. Harris</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14166

CERTIFICATE OF DEATH

14111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 61 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 1404 Annapolis Road			
3. NAME OF DECEASED (Type or print) First Denise Middle Loretta Last Moog				4. DATE OF DEATH Month December Day 11 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1951	
9. AGE (In years lost birthday) 9 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME Otis Moog				14. MOTHER'S MAIDEN NAME Geraldine Poehlitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 1973-4 IMMEDIATE CAUSE (a) Neuroblastoma with Metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1973-4 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 Months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 11, 19 60 , to December 11, 19 60 , that I last saw the deceased alive on December 11, 19 60 , and that death occurred at 3:45A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward E. Morse				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) Edward E. Morse, M.D.				DATE SIGNED 12/11/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-15-60			
22c. NAME OF CEMETERY OR CREMATORY Glen Haven				22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Tickner's F. H., Balto., Md.				24a. REC'D BY REGISTRAR DATE DEC 14 '60			
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11166

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1930		Baltimore, Md	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Physician's Title	
Jan 15, 1975		10:00 AM		Home		[Signature]		MD	
Attending Physician		Medical Examiner		Nurse		Funeral Home		Burial Place	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
[Title]		[Title]		[Title]		[Title]		[Title]	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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14167
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14112

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John		c. LENGTH OF STAY IN 1b 58 Cabin John	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6521-75th Street		d. STREET ADDRESS 6521-75th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle E Last Morgal		4. DATE OF DEATH Month December Day 17 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David L. Beall		14. MOTHER'S MAIDEN NAME Annie Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ralph L. Morgal-son-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis DUE TO 422 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Cirrhosis of Liver DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 YRS 10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1950 to Jan 1960 , that (I) (we) last saw the deceased alive on Dec 14 19 60 , and that death occurred at 2:30 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Leo I Oenovan MD		22b. DATE SIGNED 12/17/60	
22c. PHYSICIAN'S NAME (Type) LEO I OENOVAN MD		22d. ADDRESS 8218 WISCONSIN AVE BETHESDA 14 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/20/60	
23c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		23d. LOCATION (City, town, or county) (State) Potomac, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE DEC 21 '60	
ADDRESS Behhesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

11111

John
John

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1921-1921

14168

CERTIFICATE OF DEATH

Reg. Dist. No.

14113

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7100 Oak Forest Lane				e. STREET ADDRESS 7100 Oak Forest Lane			
3. NAME OF DECEASED (Type or print) First ANDREW Middle J Last MORRIS				4. DATE OF DEATH Month Dec. Day 31 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1891		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 4 Days 4	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Southern R. R.		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wallace Morris				14. MOTHER'S MAIDEN NAME Nellie Bain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT 5404 Broad Branch Rd. N. W. Andrew J. Morris, Jr.--son			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 181-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial Infarction 1951							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____	(State) _____
21. I certify that I attended the deceased from April, 1943 , to Dec. 31, 1960 , that I last saw the deceased alive on Dec. 30, 1960 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gilbert B Rude				ADDRESS (Street; city or town, state) 3900 Military Rd N.W.			
PHYSICIAN'S NAME (Type) Gilbert B Rude				DATE SIGNED 12/31/60 196			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 3 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JENNINGS		SEX Male		AGE 31		DATE OF DEATH Dec. 31, 1918	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Laborer		CAUSE OF DEATH Influenza		PLACE OF DEATH Home	
NAME OF DECEASED JENNINGS		SEX Male		AGE 31		DATE OF DEATH Dec. 31, 1918	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Laborer		CAUSE OF DEATH Influenza		PLACE OF DEATH Home	
NAME OF DECEASED JENNINGS		SEX Male		AGE 31		DATE OF DEATH Dec. 31, 1918	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Laborer		CAUSE OF DEATH Influenza		PLACE OF DEATH Home	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A CLERK OF A HOSPITAL OR A CLERK OF A COUNTY OR CITY HEALTH DEPARTMENT. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON.

14169

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14114

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WINIFRED S. MULCAHY</u>		4. DATE OF DEATH <u>Dec. 2, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1914</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Wyoming</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred N. Stuart</u>		14. MOTHER'S MAIDEN NAME <u>Louise Booker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Husband (Bertram Mulcahy) Same as above</u>	
17. INFORMANT <u>Husband (Bertram Mulcahy)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> <u>330x</u> DUE TO <u>Essential hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> (c) <u>Essential hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> to <u>12/2</u> , 19 <u>60</u> , that (I) (we) lost saw the deceased alive on <u>12/2</u> 19 <u>60</u> , and that death occurred at <u>6:15</u> AM, from the causes and on the date stated above.		22a. SIGNATURE <u>Horace W. Bernton, M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/2/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton</u>		22d. ADDRESS <u>10511 Summit Ave., Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-6-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>DEC 6 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14139

CERTIFICATE OF DEATH

7501 Soldiers Rd.

WEDNESDAY

WEDNESDAY

JULY 8, 1914

Booker

1

10311 Sunset Ave., Kensington, Md.

Horace V. Harrison

Funeral 12-8-80 Date of Death Cem. Montgomery Co. La., Md.

JOHN A. SMITH, Betters, Md.

CERTIFICATE OF DEATH

Reg. Dist. No.

14115

14170

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9514 Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Mullinix</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1870</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Clarksburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Hilton</u>		14. MOTHER'S MAIDEN NAME <u>Frances C. Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>William M. Mullinix, Damascus, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 15, 1942</u> to <u>12/19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>60</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kerr</u>		ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>		DATE SIGNED <u>12/19/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Wolsworth</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kerr</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14170

NAME

DATE

RESIDENCE

PLACE

CAUSE

TIME

AGE

SEX

DATE

TIME

PLACE

PLACE

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14171
14116
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 107 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River d. STREET ADDRESS 710 MEMQ, Naval Air Station e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gladys Middle O'Neal Last MURPHY		4. DATE OF DEATH Month December Day 24 Year 1960					
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-18	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Florida			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Otis GOODSON		14. MOTHER'S MAIDEN NAME Shulia HOWELL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage, site undetermined DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Carcinoma, cervix DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 8 19 60 to Dec. 24 19 60 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on Dec. 24 19 60 , and that death occurred at 6:05 PM M, from the causes and on the date stated above.							
22a. SIGNATURE Arthur O. Anctil, Jr. M.D.		22b. DATE SIGNED 12-25-60		22c. PHYSICIAN'S NAME (Type) A. O. ANCTIL, JR., LT, MC, USN			
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National			
23d. LOCATION (City, town, or county) (State) Arlington Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE B. C. Mattingly Mattingly Funeral Home, Leonardtown, Md.		25a. REC'D BY REGISTRAR DATE DEC 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

14171

Handwritten signature

Maryland

Non-Germany

Patuxent River

107 days

Bohemia (Prussia)

110 Mares, Naval Air Station

U. S. Naval Hospital

December 24

MURPHY

O'Neal

Gladys

42

1-12-10

Canadian

Female

USA

Florida

Hamlet

EMILIE HOWELL

JOHN GOODSON

Hospital Records

No

Gastrointestinal hemorrhage, acute undetermined

Cervix, cervix

Dec. 24

Sept. 8

Dec. 24

12-22-09

U. S. Naval Hospital, Bethesda, Md.

Virginia

Arlington

Arlington National

12-22-09

Female

National Naval Hospital, Bethesda, Md.

14172 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14117

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 District of Columbia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>				d. STREET ADDRESS <u>15501 Albemarle St. NW</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Mary Murray</u>				4. DATE OF DEATH Month Day Year <u>Dec. 2, 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 8, 1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private Residence</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
13. FATHER'S NAME <u>Patrick Murray</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Mc Nulty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. James Murray 5501 Albemarle Wash. DC St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of</u> DUE TO (c) <u>Carcinoma of sigmoid</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1960</u> to <u>Dec 2, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 20, 1960</u> , and that death occurred at <u>158</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John C. Murphy</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>JOHN C. MURPHY M.D.</u>				22d. ADDRESS <u>1801 EYE ST NW WASHINGTON D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>DEC. 5, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Dole</u> ADDRESS <u>2224 Wisconsin Wash D.C.</u>				25. REC'D BY REGISTRAR DATE <u>DEC 7 '60</u>		26. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1 A

Her death. Page 4
General director

CERTIFICATE OF DEATH

Reg. Dist. No.

14118

14014

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW YORK b. COUNTY NEW YORK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW YORK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lebeau Gardens Nursing Home		d. STREET ADDRESS 345 East 94th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank (NMI) Neubauer		4. DATE OF DEATH Month December Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 11, 1901
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Brewery	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown Neubauer		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Mrs. John W. Neubauer, 11,941 Bluhill Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrothorax, Left 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinomatosis DUE TO (c) Carcinoma of the Stomach		INTERVAL BETWEEN ONSET AND DEATH 2 WKS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 12, 1960 to Dec 13, 1960 , that I last saw the deceased alive on Dec 13, 1960 , and that death occurred at 11:00 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Thibadeau		ADDRESS (Street, city or town, state) 10609 Concord Street Kensington, Maryland	
DATE SIGNED Dec 13, 1960			
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL	22b. DATE THEREOF 12/17/60	22c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY	22d. LOCATION (City, town, or county) (State) ASTORIA, LONG ISLAND, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE DEC 19 60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL ATTENDING PHYSICIAN: Signatures that the death certificate be executed within 24 hours after death.

VS A15 (4)
15M 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14014

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

14014

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FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14119

14070

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest city) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box Car B+O R R</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Irene Effie Nicholson</u>				4. DATE OF DEATH <u>Dec 3 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-1912</u>		9. AGE (In years last birthday) <u>48</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>Henry T. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Emma B. Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>William E. Nicholson Gaithersburg, Md</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute emphysema with alveolar ruptures</u> 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intervalveolar hemorrhages</u> DUE TO (c) <u>Acute Alcoholism</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Curlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Curlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank B. Gaithersburg</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>DEC 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krum</u>	

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14010

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

1. Name of deceased: [illegible]
2. Age: [illegible] Sex: [illegible]
3. Date of death: [illegible]
4. Place of death: [illegible]
5. Cause of death: [illegible]
6. Manner of death: [illegible]
7. Signature of examiner: [illegible]
8. Date: [illegible]

1. Name of deceased: [illegible]
2. Age: [illegible] Sex: [illegible]
3. Date of death: [illegible]
4. Place of death: [illegible]
5. Cause of death: [illegible]
6. Manner of death: [illegible]
7. Signature of examiner: [illegible]
8. Date: [illegible]

REGISTRATION

TO BE FILLED IN BY THE REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14120

14071

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write BUR and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN lb <u>6 mo</u>		d. STREET ADDRESS <u>431 N. Frederick Ave Apt 102</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>431 N. Frederick Ave Apt 102</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruben Young Nicholson</u>		4. DATE OF DEATH <u>Dec 2 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-21</u>
9. AGE [in years last birthday] <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Roads</u>	11. BIRTHPLACE (State or foreign country) <u>md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm Young Nicholson</u>	
14. MOTHER'S MAIDEN NAME <u>Isabelle Bowrongher</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes W.W. II</u>	
16. SOCIAL SECURITY NO. <u>212-20-2219</u>		17. INFORMANT <u>Elsie Nicholson - Steu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction left ventricular wall</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Atherosclerosis</u> DUE TO <u>Coronary Atherosclerosis</u> (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bruschat</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHAT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-3-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-5-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Hines</u>	
ADDRESS <u>Laytonsville, Md.</u>		24b. REGISTRAR'S SIGNATURE	

14071

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and printed form fields. Visible fragments include:]

NAME OF DECEASED: *[illegible]*
AGE: *[illegible]*
SEX: *[illegible]*
DATE OF DEATH: *[illegible]*
PLACE OF DEATH: *[illegible]*
CAUSE OF DEATH: *[illegible]*
MANNER OF DEATH: *[illegible]*
SIGNATURE OF EXAMINER: *[illegible]*
DATE: *[illegible]*

[Vertical text on the right margin, likely a filing or processing stamp, mostly illegible.]

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 2
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14173
14121
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Seabrook	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook 67X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 802 East Parsonage Road	
3. NAME OF DECEASED (Type or print) First Kanesuke Middle Nishimoto Last Nishimoto		4. DATE OF DEATH Month 12 Day 6 Year 1960	
5. SEX Male	6. COLOR OR RACE Y	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/84
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gardener	
11. BIRTHPLACE (State or foreign country) Japan		12. CITIZEN OF WHAT COUNTRY? U.S.A. for 5 yrs.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Ochika Kawanroto	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 137-22-7475	
17. INFORMANT Tsutayo Nishimoto-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, recent, 420.1 DUE TO apex Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis, left descending DUE TO (c) Coronary atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour o. m. NONE 19 p. m. NONE		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-2 19 60 to 12-6 19 60 , that (I) (we) last saw the deceased alive on 12-6 19 60 , and that death occurred at 2:30 M, from the causes and on the date stated above.			
22a. SIGNATURE James McCarrik M.D.		22b. DATE SIGNED 12-6-60	
22c. PHYSICIAN'S NAME (Type) James McCarrik		22d. ADDRESS 3711 Leland St., Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12/10/60	
23c. NAME OF CEMETERY OR CREMATORY Silverbrook		23d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR DEC 9 '60	
ADDRESS 1331 E. Montg. Ave Rockville, Md.		25b. REGISTRAR'S SIGNATURE C. L. S. Kline	

CERTIFICATE OF DEATH

11173

101

Myocardial infarction
Cerebral thrombosis
Cerebral arteriosclerosis

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14174
14122
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield Manor		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield Manor 57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5400 Christy Drive		d. STREET ADDRESS 5400 Christy Drive 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE H. NORRIS		4. DATE OF DEATH Month Day Year Dec. 2, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 1 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Norris		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-10-9156	
17. INFORMANT Daughter		Address Same as #2 Mrs. Bernice N. Kirkpatrick	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis (c) 1 hour 1-year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 hour 1-year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1950 to Dec 2, 1960 , that (I) (we) last saw the deceased alive on Dec 1, 1960 , and that death occurred at 3 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. McMahon		22b. DATE Dec. 2, 1960	
22c. PHYSICIAN'S NAME (Type) THOMAS F. McMAHON		22d. ADDRESS 3000 Conn. Ave., N.W., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/5/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR DEC 6 '60		25b. REGISTRAR'S SIGNATURE Arthur L. House	

1412

CERTIFICATE OF DEATH

1412

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
SIGNATURE OF REGISTRAR

DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH
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DATE OF DEATH
PLACE OF DEATH

14175
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14123
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
c. LENGTH OF STAY IN 1b 2hrs. 44min.				d. STREET ADDRESS 4403 Maple Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Baby Girl		Middle OATES		Last OATES	
4. DATE OF DEATH		Month December		Day 8		Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-60		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. 2 44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Alexander OATES				14. MOTHER'S MAIDEN NAME Meredith STRINGFIELD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (F) John A. Oates, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Atelectasis 762.5 DUE TO Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec. 8 1960 to Dec. 8 1960 that (I) (we) lost saw the deceased alive on Dec. 8 1960 , and that death occurred at 7:10PM from the causes and on the date stated above.							
22a. SIGNATURE F. W. Grello				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-9-60	
22c. PHYSICIAN'S NAME (Type) F. W. GRELLO, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-10-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				25a. REC'D BY REGISTRAR DATE DEC 12 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

R.A. Thompson, General Home, Bethesda, Md.

Operation 12-10-60 Cedar Hills Cemetery Baltimore, Maryland

T. W. GREEN, Lt, MC, USN U. S. Naval Hospital, Bethesda, Md.

12-4-60

Dec. 8

Dec. 9 7:10 PM

Dec. 9

CONFIDENTIAL

John A. Green

No. None (3) John A. Green, name as TS above

John Alexander Green

Married on 12-10-60

Female Caucasian 12-8-60 Maryland USA

Baby Girl

DATE

December

8 60

U. S. Naval Hospital

4403 Maple Ave.

Bethesda (Md.)

Chas. H. Green

Montgomery Maryland Montgomery

11175

CERTIFICATE OF DEATH

11175

CERTIFICATE OF DEATH

Reg. Dist. No. 14124

14065

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 20 yrs @	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Chevy Chase		d. STREET ADDRESS 1113 Summerfield Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 Summerfield Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE M. O'DONNELL		4. DATE OF DEATH Month Day Year December 28, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1871
9. AGE (In years last birthday) yrs. 89	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Ireland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Denis Long		14. MOTHER'S MAIDEN NAME Johanna Donoghue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Julia O'Donnell-#2d.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cerebral Vascular Ischemia 2 yrs 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis 20 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Myocardial Ischemia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-1-55 , 19__, to 12-28-60 , 19__, that I last saw the deceased alive on 12-28-60 , 19__, and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew J. Betz		ADDRESS (Street, city or town, state) DATE SIGNED 5412 Colo. Ave NW Wash D.C.	
PHYSICIAN'S NAME (Type) Andrew J. Betz, M.D.		5412 Col. Ave., NW Wash. 11, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		24a. REC'D BY REGISTRAR DEC 30 '60	
ADDRESS 317 Pa. Ave., SE DC3		24b. REGISTRAR'S SIGNATURE Andrew J. Betz	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14002

County of ... State of ...
I, the undersigned, being a duly qualified physician, do hereby certify that ...

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14049

14125

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>45 Bethesda, Md.</u>			
c. LENGTH OF STAY IN 1b <u>3 hours</u>				d. STREET ADDRESS <u>19118 Kirkdale Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert NMN Oelschlaeger</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/9/85</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>7</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statistician</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Oelschlaeger</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>136-01-0286</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.2</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Angina Pectoris</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 5, 1960</u> to <u>Dec 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 7, 1960</u> and that death occurred at <u>3:45 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George B. Patrick Jr</u>				22b. DATE SIGNED <u>12-7-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>George B. Patrick, Jr MD.</u>				22d. ADDRESS <u>9221 Collesville Rd Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		23b. DATE THEREOF <u>12/10/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Restland Mem. Prk</u>		23d. LOCATION (City, town, or county) (State) <u>Hanover, New Jersey</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>Behtesda, Maryland</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>				DATE <u>12 DEC 8 '60</u>			

MEDICAL CERTIFICATION

12043

CENTRAL BANK OF DEATH

12043

12043

ROBERT A. FREEMAN, Secretary, and
ROBERT A. FREEMAN, Secretary, and

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

141176

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14126

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Neil Middle James Last O'HARA		4. DATE OF DEATH Month December Day 6 Year 19 60		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-4-96		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 6 Hours 19 Min. 60					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Patrick O'HARA		14. MOTHER'S MAIDEN NAME Mary MAHER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE COR PULMONALE 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EMPHYSEMA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS YEARS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 3 19 60 to Dec. 6 19 60 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 6 19 60 , and that death occurred at 6:35AM from the causes and on the date stated above.		22a. SIGNATURE Russell Miller, Jr. MD		22b. DATE SIGNED 12-6-60		22c. PHYSICIAN'S NAME (Type) Russell MILLER, LT, MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS		22g. REC'D BY REGISTRAR DEC 7 '60		22h. REGISTRAR'S SIGNATURE Arthur S. Hume		22i. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia		23e. FUNDAL DIRECTOR'S SIGNATURE Simmons Bros		23f. ADDRESS Simmons Bros., 1661 Good Hope Rd., SE, WashDC		23g. REC'D BY REGISTRAR DEC 7 '60		23h. REGISTRAR'S SIGNATURE Arthur S. Hume		23i. ADDRESS			

Colonel Price, 1001 Good Hope Rd, SE, Wash DC

Serial 12-2-00 Arlington National Arlington Virginia

Russell Miller, LT, MC USN

U. S. Naval Hospital, Bethesda, Md.

12-2-00

Dec. 2 60

Dec. 2 60 6:35AM

Dec. 2 60

60

Private O'HARA

1 Mary Maher

Mariner (Retired)

U. S. Navy

New York

USA

Memo

Concussion

1

Well

3 days

O'HARA

December 2 60

U. S. Naval Hospital

400 Mills Ave.

Bethesda (Retired)

3 days

Blinded during

12-2-00

12-2-00

12-2-00

12-2-00

CERTIFICATE OF DEATH

12-2-00

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

14177

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14127

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CURTIS Middle BLAIR Last O'KEEFE				4. DATE OF DEATH Month 12 Day 7 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/5/60	
9. AGE (In years lost birthday) yrs.		10. AGE (In years lost birthday) yrs.		11. AGE (In years lost birthday) yrs.		12. AGE (In years lost birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME DONALD GRANVILLE O'KEEFE				14. MOTHER'S MAIDEN NAME SALLY KATHLEEN SIMONS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis of lungs; bilateral AND BRONCHO PNEUMONIA, BILATERAL Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) ASPIRATION OF AMNIOTIC FLUID DUE TO (c) ASPIRATION OF AMNIOTIC FLUID PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 1 DAY 2 DAYS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/5/60 to 12/7/60 , that (I) was last saw the deceased alive on 12/7/60 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles S. Whitaker				22b. DATE SIGNED 12/8/60			
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.				22d. ADDRESS CLARKSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Dec 9-60		23c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery		23d. LOCATION (City, town, or county) (State) Clarksville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James M. [Signature]				25a. REC'D BY REGISTRAR DATE DEC 14 '60			
25b. REGISTRAR'S SIGNATURE Charles S. [Signature]							

2073192XV4

11173

CERTIFICATE OF DEATH

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

PLACE OF DEATH

10

11

12

13

14

15

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

10

11

12

Handwritten signature and notes at the bottom of the page.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14128

14082

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE c. LENGTH OF STAY IN 1b 4 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4610 WILWYN WAY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 4610 WILWYN WAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
NAME OF DECEASED (Type or print) First CATHERINE Middle MAY Last ORPHANOS			4. DATE OF DEATH Month DEC. Day 27 Year 1960				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/08	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLORAL ARRANGER		10b. KIND OF BUSINESS OR INDUSTRY FLORIST	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN ROBERT BYRON			14. MOTHER'S MAIDEN NAME KATHERINE BOWERS TURNER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-14-3265	17. INFORMANT Address Mr. Achilles Orphanos, 4610 Wilwyn Way				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Coronary Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arterial Hypertension (b) Arterial Hypertension (c) Arterial Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Thrombosis old, multiple.					INTERVAL BETWEEN ONSET AND DEATH 1 hour Undetermined		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from April 1, 1957 to Dec 27, 1960 that (I) (we) last saw the deceased alive on Nov 26, 1960 , and that death occurred at 4 PM from the causes and on the date stated above.							
22a. SIGNATURE George L Ball		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Dec 27, 1960				
22c. PHYSICIAN'S NAME (Type) George L Ball		22d. ADDRESS 10670 Georgia Ave Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/30/60	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	23d. LOCATION (City, town or county) (State) MONTGOMERY COUNTY, MD.				
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	25a. REGISTRY REGISTRAR SAR 3 61	25b. REGISTRAR'S SIGNATURE Raymond A. Jaska			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner, Montgomery County, D. C. to be informed concerning circumstances and he authorized to sign certificate of death.

Broschart informed concerning circumstances and he authorized to sign certificate of death.

1415

CERTIFICATE OF DEATH

14083

Blank certificate form with horizontal lines and two punch holes on the right side.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>5075 Bradley Blvd, Apt 3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5075 Bradley Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Barbara Elizabeth Ostroski</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-28</u>	9. AGE (In years last birthday) <u>32 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cal.</u>		11. BIRTHPLACE (State or foreign country) <u>Cal.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Geo. L. Morris</u>				14. MOTHER'S MAIDEN NAME <u>Kara Stewart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes Unknown</u>		17. INFORMANT <u>John Ostroski</u>		Address <u>Husband</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Hemorrhage + laceration</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound in skull (rt)</u> DUE TO (c) <u>Sudden</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Self-inflicted bullet wound in skull</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound in skull</u>					
20c. TIME OF INJURY Month, Day, Year <u>12-29-1960</u> Hour <u>2</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>12-29-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 30 60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Carl S. Frank</u>			

MEDICAL CERTIFICATION

1

0

2

14129

14178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-111111

1

NO

Yes

Handed

Robert A. Pumphrey, Bethesda, Maryland
Buried 1-24-61 Arlington Nat. C.
Virginia

1
M
074
I

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14179

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14130

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>18 hours</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>111202 Mitscher St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Paper</u> Last <u>Paper</u>				4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 23, 1923</u>	
9. AGE (In years last birthday) <u>37 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Gortler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>351-14-1984</u>		17. INFORMANT (Brother) <u>Hyman Paper</u> Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO <u>Spontaneous</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Rupture Cerebral Blood Vessel;</u> DUE TO (c) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>28 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-5-60</u> 19 <u>60</u> to <u>12-6-60</u> 19 <u>60</u> , that (I) (we) lost the deceased alive on <u>12-6</u> 19 <u>60</u> , and that death occurred at <u>2:34</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Morris Perry</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>				22d. ADDRESS <u>11602 Georgia Avenue SSpg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 7, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arl. Nat'l. Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gooding Funeral Home #217-9 St. Paul</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 7 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

14178

CERTIFICATE OF DEATH

14178

1911-1-121

11025 Georgia Avenue, S.E., Wash., D.C.

Arlington, Va.

Ariz. Natl. Cem.

North Perry

Dec 7, 1900

Ariz.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. M

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14131											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>12 yrs.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>21 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10215 Woodman Circle</u>				d. STREET ADDRESS <u>10215 Woodman Circle</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph Perego</u>		First Middle Last		4. DATE OF DEATH <u>Dec 5 1960</u>		Month Day Year		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-91</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>				11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Perego</u>				14. MOTHER'S MAIDEN NAME <u>Louise Oakley</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>579-12-2949</u>				17. INFORMANT <u>Elva Perego</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 hrs</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary Embolism</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>DEC. 8, 1960</u>				22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>			
22d. LOCATION (City, town, or country) (State) <u>PRINCE GEORGE'S CO. MARYLAND</u>				23. FUNERAL DIRECTOR <u>WALTER E. PUMPHREY, INC.</u>				24a. REC'D BY REGISTRAR <u>DEC 14 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>				24c. ADDRESS <u>8434 GEORGIA AVE., SILVER SPRING, MD.</u>				24d. ADDRESS (Street, city, town, or county) <u>12-5-60</u>			

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14132

14180

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 21 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 59 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7700 Old Chester Rd.		d. STREET ADDRESS 7700 Old Chester Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) JANE KIMBALL PETERSON	4. DATE OF DEATH Month Dec. Day 9, Year 1960
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1877	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 4 Days 14	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Roxbury, Kansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME Arba D. Kimball	14. MOTHER'S MAIDEN NAME Julia Reynolds
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Sister Mrs. Bess K. Kicklighter Address Same as Item 2.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive heart disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 6 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **January, 1958**, to **9 Dec**, 19**60**, that I last saw the deceased alive on **28 Nov**, 19**60**, and that death occurred at **5:30 PM**, from the causes and on the date stated above.

ACTUAL SIGNATURE Herbert Martin	M.D. 5029 Bethesda Cwp	DATE SIGNED 9 Dec 60
PHYSICIAN'S NAME (Type) HERBERT MARTIN JR Bethesda, Md		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	22b. DATE THEREOF 12-11-60	22c. NAME OF CEMETERY OR CREMATORY Patton's Cemetery	22d. LOCATION (City, town, or county) (State) LaPorte, Indiana
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23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY	ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR DEC 15 60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11180

<p>1. Name of deceased: <u>JOHN J. HENRY</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1877-1-14</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1910-1-10</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Duration of illness: <u>10 days</u></p>	
<p>9. Name of physician: <u>Dr. J. J. Henry</u></p>		<p>10. Name of funeral home: <u>John J. Henry</u></p>	
<p>11. Name of informant: <u>John J. Henry</u></p>		<p>12. Address of informant: <u>100 N. 1st St.</u></p>	
<p>13. Name of registrar: <u>John J. Henry</u></p>		<p>14. Address of registrar: <u>100 N. 1st St.</u></p>	
<p>15. Name of witness: <u>John J. Henry</u></p>		<p>16. Address of witness: <u>100 N. 1st St.</u></p>	
<p>17. Name of witness: <u>John J. Henry</u></p>		<p>18. Address of witness: <u>100 N. 1st St.</u></p>	
<p>19. Name of witness: <u>John J. Henry</u></p>		<p>20. Address of witness: <u>100 N. 1st St.</u></p>	
<p>21. Name of witness: <u>John J. Henry</u></p>		<p>22. Address of witness: <u>100 N. 1st St.</u></p>	
<p>23. Name of witness: <u>John J. Henry</u></p>		<p>24. Address of witness: <u>100 N. 1st St.</u></p>	
<p>25. Name of witness: <u>John J. Henry</u></p>		<p>26. Address of witness: <u>100 N. 1st St.</u></p>	
<p>27. Name of witness: <u>John J. Henry</u></p>		<p>28. Address of witness: <u>100 N. 1st St.</u></p>	
<p>29. Name of witness: <u>John J. Henry</u></p>		<p>30. Address of witness: <u>100 N. 1st St.</u></p>	
<p>31. Name of witness: <u>John J. Henry</u></p>		<p>32. Address of witness: <u>100 N. 1st St.</u></p>	
<p>33. Name of witness: <u>John J. Henry</u></p>		<p>34. Address of witness: <u>100 N. 1st St.</u></p>	
<p>35. Name of witness: <u>John J. Henry</u></p>		<p>36. Address of witness: <u>100 N. 1st St.</u></p>	
<p>37. Name of witness: <u>John J. Henry</u></p>		<p>38. Address of witness: <u>100 N. 1st St.</u></p>	
<p>39. Name of witness: <u>John J. Henry</u></p>		<p>40. Address of witness: <u>100 N. 1st St.</u></p>	
<p>41. Name of witness: <u>John J. Henry</u></p>		<p>42. Address of witness: <u>100 N. 1st St.</u></p>	
<p>43. Name of witness: <u>John J. Henry</u></p>		<p>44. Address of witness: <u>100 N. 1st St.</u></p>	
<p>45. Name of witness: <u>John J. Henry</u></p>		<p>46. Address of witness: <u>100 N. 1st St.</u></p>	
<p>47. Name of witness: <u>John J. Henry</u></p>		<p>48. Address of witness: <u>100 N. 1st St.</u></p>	
<p>49. Name of witness: <u>John J. Henry</u></p>		<p>50. Address of witness: <u>100 N. 1st St.</u></p>	
<p>51. Name of witness: <u>John J. Henry</u></p>		<p>52. Address of witness: <u>100 N. 1st St.</u></p>	
<p>53. Name of witness: <u>John J. Henry</u></p>		<p>54. Address of witness: <u>100 N. 1st St.</u></p>	
<p>55. Name of witness: <u>John J. Henry</u></p>		<p>56. Address of witness: <u>100 N. 1st St.</u></p>	
<p>57. Name of witness: <u>John J. Henry</u></p>		<p>58. Address of witness: <u>100 N. 1st St.</u></p>	
<p>59. Name of witness: <u>John J. Henry</u></p>		<p>60. Address of witness: <u>100 N. 1st St.</u></p>	
<p>61. Name of witness: <u>John J. Henry</u></p>		<p>62. Address of witness: <u>100 N. 1st St.</u></p>	
<p>63. Name of witness: <u>John J. Henry</u></p>		<p>64. Address of witness: <u>100 N. 1st St.</u></p>	
<p>65. Name of witness: <u>John J. Henry</u></p>		<p>66. Address of witness: <u>100 N. 1st St.</u></p>	
<p>67. Name of witness: <u>John J. Henry</u></p>		<p>68. Address of witness: <u>100 N. 1st St.</u></p>	
<p>69. Name of witness: <u>John J. Henry</u></p>		<p>70. Address of witness: <u>100 N. 1st St.</u></p>	
<p>71. Name of witness: <u>John J. Henry</u></p>		<p>72. Address of witness: <u>100 N. 1st St.</u></p>	
<p>73. Name of witness: <u>John J. Henry</u></p>		<p>74. Address of witness: <u>100 N. 1st St.</u></p>	
<p>75. Name of witness: <u>John J. Henry</u></p>		<p>76. Address of witness: <u>100 N. 1st St.</u></p>	
<p>77. Name of witness: <u>John J. Henry</u></p>		<p>78. Address of witness: <u>100 N. 1st St.</u></p>	
<p>79. Name of witness: <u>John J. Henry</u></p>		<p>80. Address of witness: <u>100 N. 1st St.</u></p>	
<p>81. Name of witness: <u>John J. Henry</u></p>		<p>82. Address of witness: <u>100 N. 1st St.</u></p>	
<p>83. Name of witness: <u>John J. Henry</u></p>		<p>84. Address of witness: <u>100 N. 1st St.</u></p>	
<p>85. Name of witness: <u>John J. Henry</u></p>		<p>86. Address of witness: <u>100 N. 1st St.</u></p>	
<p>87. Name of witness: <u>John J. Henry</u></p>		<p>88. Address of witness: <u>100 N. 1st St.</u></p>	
<p>89. Name of witness: <u>John J. Henry</u></p>		<p>90. Address of witness: <u>100 N. 1st St.</u></p>	
<p>91. Name of witness: <u>John J. Henry</u></p>		<p>92. Address of witness: <u>100 N. 1st St.</u></p>	
<p>93. Name of witness: <u>John J. Henry</u></p>		<p>94. Address of witness: <u>100 N. 1st St.</u></p>	
<p>95. Name of witness: <u>John J. Henry</u></p>		<p>96. Address of witness: <u>100 N. 1st St.</u></p>	
<p>97. Name of witness: <u>John J. Henry</u></p>		<p>98. Address of witness: <u>100 N. 1st St.</u></p>	
<p>99. Name of witness: <u>John J. Henry</u></p>		<p>100. Address of witness: <u>100 N. 1st St.</u></p>	

14181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14133

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>14 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>1 Route 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ronald L Phillips</u>			4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>19 60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1958</u>		9. AGE (In years last birthday) <u>2 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Houston Prather</u>			14. MOTHER'S MAIDEN NAME <u>Eliza Phillips</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Eliza Phillips</u> Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosnau</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-12-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosnau</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>	
22d. LOCATION (City, town, or county) <u>Laytonville, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

— 52 —

14182

CERTIFICATE OF DEATH

14134

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE D.C. b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simons Rest Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
f. STREET ADDRESS 804 Butternut Street, N.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnese Middle Pieri Last Pieri				4. DATE OF DEATH Month Dec. Day 6 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/16/1879	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Adriano Giannini				14. MOTHER'S MAIDEN NAME Semira —			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Semira M. Ford--9711 Holmhurst Road Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO (c) 3 days 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NEPHROSCLEROSIS; CEREBRAL ARTERIOSCLEROSIS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 2 , 1960, to Dec 6 , 1960, that I last saw the deceased alive on Dec 6 , 1960, and that death occurred at 6:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles S. Whitaker M.D. CHARLES S. WHITAKER, M.D. CLARKSVILLE, MD. 12/6/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial							
22b. DATE THEREOF 12/9/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Mausoleum Prince Georges County, Md.		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W. Washington, D.C.				24a. REC'D BY REGISTRAR DEC 8 '60		24b. REGISTRAR'S SIGNATURE Charles S. Whitaker	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

<div> <div> <div>14183</div> <div>14135</div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>VS. A15ME</div> <div>SM 7/59</div> </div> </div> <div> <div> <div>14183</div> <div>14135</div> </div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>VS. A15ME</div> <div>SM 7/59</div> </div> </div> </div>											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY 19 HRS. c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND MONTGOMERY b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS RT. 2 e. IS RESIDENCE <input type="checkbox"/> A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CORA ALTIE PRESLEY 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Jan. 15/1888 9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						4. DATE OF DEATH DECEMBER 6 19 60 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (State or foreign country) VIRGINIA 12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME FLOYD RAY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no 16. SOCIAL SECURITY NO. 21-24-2268 17. INFORMANT CELIA CUMPTON Address						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE DUE TO (b) FRACTURE OF SKULL DUE TO (c) STRUCK BY AUTO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 18 1/2 HRS.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) COMPOUND FRACTURE OF RIGHT LEG - FRACTURE 3RD RIB, RIGHT					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PEDESTRIAN STRUCK BY AUTOMOBILE 20c. TIME OF INJURY Month, Day, Year 5:25 12/5/60 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MD. R 115 20f. (City or town) (County) (State) GAITHERSBURG, MONTG. MD.						21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/7/60 GAITHERSBURG, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12-9-60 22c. NAME OF CEMETERY OR CREMATORY Flower Hill 22d. LOCATION (City, town, or country) (State) Montgomery County, Md.						23. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 24a. REC'D BY REGISTRAR DEC 9 '60 24b. REGISTRAR'S SIGNATURE <i>Charles S. H...</i>					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14050
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14136

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				d. STREET ADDRESS <u>555 University Blvd., E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mrs. Ollie</u> Middle <u>Blanche</u> Last <u>Printz</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-93</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James A. SOMERS</u>				14. MOTHER'S MAIDEN NAME <u>Artie Seal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-28-4586</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dilatation Commao duct secondary to fibrosis sphincter Oddi</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 7th</u> 19 <u>60</u> to <u>Dec 2nd</u> 19 <u>60</u> ; that (I) (we) last saw the deceased alive on <u>Dec 2nd</u> 19 <u>60</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Lysle Williams</u> M.D.				22b. DATE SIGNED <u>Dec 2nd 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lysle Williams M.D.</u>				22d. ADDRESS <u>7717 Garland Ave, Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/5/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>DEC 7 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14051
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14137

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OAKHAVEN CONVELESCENT HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles NELSON PUMPHREY		4. DATE OF DEATH Month DECEMBER Day 26 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/86
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRM Operator		10b. KIND OF BUSINESS OR INDUSTRY Dupont Laundry	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES B. PUMPHREY		14. MOTHER'S MAIDEN NAME MOLLIE H. PLUMMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-01-6316	
17. INFORMANT Mrs. James G. Berry, 637 Longfellow St.		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163 X IMMEDIATE CAUSE (a) Carcinoma of Lung - right base DUE TO (b) Cause of Cancer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/20/1960 to 12/26/1960 that (I) (we) lost saw the deceased alive on 12/24/1960 and that death occurred on 12/26/1960 from the causes and on the date stated above.			
22a. SIGNATURE Chas H Wolohin, MD		22b. DATE SIGNED 12/26/60	
22c. PHYSICIAN'S NAME (Type) Chas H Wolohin		22d. ADDRESS 7401 Blair Rd NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/28/60	
23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Raymond A. Ziska		25a. REC'D BY REGISTRAR DATE JAN 3 '61	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE William S. Thomas	

EXHIBIT 10-1

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14074

CERTIFICATE OF DEATH

Reg. Dist. No.

14138

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MD.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM 3000 McCOMAS.				d. STREET ADDRESS 7705-MORNINGSIDE DRIVE, N.W.			
3. NAME OF DECEASED (Type or print) First EVA Middle M. Last RAUCHENSTEIN				4. DATE OF DEATH Month DECEMBER Day 25th Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21, 1876	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 5 Days 4 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) WASHINGTON, DIST. OF COL.	
13. FATHER'S NAME SAMUEL E. SHIELDS				14. MOTHER'S MAIDEN NAME JOSEPHINE Shields			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT (Daughter) MRS. JAMES H. REES Address Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary infarction DUE TO (c) Thrombosis left femoral vein				INTERVAL BETWEEN ONSET AND DEATH 2 wks. 3 wks. 2 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D.C.				20g. (County) (State)			
21. I certify that I attended the deceased from August, 1960 , to December 24, 1960 , that I last saw the deceased alive on Dec 23, 1960 , and that death occurred at 1:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Coleman MD				ADDRESS (Street, city or town, state) 733 Sligo Ave. Dec. 25, 1960			
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN, M.D.				DATE SIGNED Silver Spring Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 28, 1960		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG CO.				ADDRESS 1300 N. STREET, N.W.		24a. REC'D BY REGISTRAR DEC 27 1960	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14184

14139

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Catherine Reichard				4. DATE OF DEATH Dec. 14, 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 12, 1870	
9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Abraham Sellers				14. MOTHER'S MAIDEN NAME Amanda Markley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Evelyn Burrows				Address 4616 Chesapeake St. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 DUE TO Myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerosis generalized (c) years							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (1) (this hospital) attended the deceased from Nov. 1954 to 12-14, 1960 , that (2) (we) last saw the deceased alive on 12-14, 1960 , and that death occurred at 3:15 M. from the causes and on the date stated above.							
22a. SIGNATURE Alfred S. Norton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/14/60	
22c. PHYSICIAN'S NAME (Type) Alfred S. Norton				22d. ADDRESS 4711 Highland Ave. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/16/60		23c. NAME OF CEMETERY OR CREMATORY St. John Reformed Cem		23d. LOCATION (City, town, or county) (State) Northampton Co. Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14052

14140

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		
c. LENGTH OF STAY IN 1b 28 days			d. STREET ADDRESS 7807 Lockney Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital					
3. NAME OF DECEASED (Type or print) Irene NMN Reichlyn			4. DATE OF DEATH Month Day Year December 23 1960		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1914	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (County & State, or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME Samuel Ruback		
14. MOTHER'S MAIDEN NAME Bessie Katz			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Washington Sanitarium & Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Brain DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of Lung (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1 month 5 months					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 Aug 1960 to 23 Dec 1960 that (I) (we) last saw the deceased alive on 22 Dec 1960 , and that death occurred at 6 PM , from the causes and on the date stated above.					
22a. SIGNATURE Thomas P Fogarty			22b. DATE SIGNED 23 Dec 1960		
22c. PHYSICIAN'S NAME (Type) Thomas P Fogarty			22d. ADDRESS 1011 Univ. Blvd E Silver Spring Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-60		23c. NAME OF CEMETERY OR CREMATORY Beth T Fildes	
23d. LOCATION (City, town or county) Balto		23e. (State) Md		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE Jack Lowrie			25. REC'D BY REGISTRAR DEC 27 '60		
25a. ADDRESS 2100 Eutaw Place			25b. REGISTRAR'S SIGNATURE Arthur E. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

14078

Received of the
Treasurer of the
University of
Cambridge
the sum of
£ 100
for the
purchase of
books
for the
Library
of the
University
of
Cambridge
on the
25th day of
December 1907
at the
University
of
Cambridge
Library
Department
Cambridge
England

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Received of the
Treasurer of the
University of
Cambridge
the sum of
£ 100
for the
purchase of
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Library
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Cambridge
on the
25th day of
December 1907
at the
University
of
Cambridge
Library
Department
Cambridge
England

14185

CERTIFICATE OF DEATH

Reg. Dist. No.

14141

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 14 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 4111 Emery Place, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eber First F. Middle Riley Last				4. DATE OF DEATH Dec. Month 7 Day 19 Year 60			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/10	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.		IF UNDER 24 HRS. Months 50 Days 50 Hours 50 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Rate Specialist				10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry F. Riley				14. MOTHER'S MAIDEN NAME Emma Eber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577-32-6783		17. INFORMANT Harry C. Riley (brother)		Address Bethesda 6622 Braeburn Pkway./	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis, left coronary artery DUE TO (c) Arterio Sclerosis severe				INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Embolus				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May , 19 60 , to 11-7 , 19 60 , that I last saw the deceased alive on 11-7 , 19 60 , and that death occurred at 11:45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4201 Fessenden DATE SIGNED 12-7-60							
ACTUAL SIGNATURE P.P. Andrews M.D.				PHYSICIAN'S NAME (Type) P.P. ANDREWS M.D. Washington 16 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/60		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 9 '60	
24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14185

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES A. HARRISON		Male		45		White		1900		Maryland	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. DISEASE OR INJURY		12. MANNER OF DEATH	
1945		10:00 AM		Home		Heart Disease		Coronary Artery Disease		Natural	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF JUDGE	
19. NAME OF PHYSICIAN		20. NAME OF REGISTRAR		21. NAME OF CLERK		22. NAME OF JUDGE		23. NAME OF WITNESS		24. NAME OF DECEASED	
Dr. J. A. Harrison		J. A. Harrison		J. A. Harrison		J. A. Harrison		J. A. Harrison		J. A. Harrison	

10. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

11. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

12. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

13. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

14. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

15. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

16. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

17. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

18. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

19. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

20. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

14186

CERTIFICATE OF DEATH

Reg. Dist. No. 14142

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson		c. LENGTH OF STAY IN 1b 76 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Edgar Roberson		4. DATE OF DEATH Month 26 Day 26 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14-1884
9. AGE (In years birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Contractor--Self employed		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin F. Roberson		14. MOTHER'S MAIDEN NAME Mollie Purdy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-2777	
INFORMANT Address Mrs Ruth Roberson, Dickerson, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 204.1 DUE TO Leukemia, Chronic Myelogenous Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Gouty Arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Oct. 1960 to 26 Dec. 1960 , that I last saw the deceased alive on 24 Dec. 1960 , and that death occurred at 2:18 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) Barnesville, Md	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-60	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton		ADDRESS Barnesville, Md	
24a. REC'D BY REGISTRAR DEC 30 '60		24b. REGISTRAR'S SIGNATURE W. L. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Montgomery
 Maryland
 Dickerson
 76 yrs

Male
 White
 Feb. 14-1934
 78
 December 19
 00
 Plumbing Contractor--Self employed
 Maryland
 U.S.
 Benjamin L. Robinson
 Nollie Turley
 Mrs. Ruth Robinson, Dickerson, Maryland
 218-32-2777

Chronic Myelogenous Leukemia
 3 days

Gordon M. Smith
 Barnsville, Md
 12-23-80
 Barnsville, Md
 Barnsville, Md

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14187

14143

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood			c. LENGTH OF STAY IN 1b 55			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6004 Highland Dr.				d. STREET ADDRESS 6004 Highland Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sadie Middle F Last Robirette				4. DATE OF DEATH Month 12 Day 3 Year 1960			
5. SEX F	6. COLOR OR RACE YY	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1884		9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William G. Firoved				14. MOTHER'S MAIDEN NAME Mary A. Shuffler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - -		17. INFORMANT Sadie F. Hughes		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO (b) Cerebral Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 days 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Rt. Femur, surgical neck Sept. 10, 1960						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct. 27, 1960 to Dec. 3, 1960 , that (I) (we) last saw the deceased alive on Nov. 26, 1960 and that death occurred at 10:50 AM , from the causes and on the date stated above.			
22a. SIGNATURE Frank S. Bacon		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) FRANK S. BACON		22d. ADDRESS 1150 - CONN. Ave. N.W. Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-6-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Go. Hawley's Sons Inc.				ADDRESS Wash. 6, D.C.		25a. REC'D BY REGISTRAR DATE DEC 6 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Dec 1911

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the original. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

<div>Item 21 Film 278 1-9-61</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>14188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14188</div>									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clinical Center, NIH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY ESSEX c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Montclair East Orange d. STREET ADDRESS 13 Academy Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Willie Robinson			4. DATE OF DEATH December 7 19 60						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1925		9. AGE (In years last birthday) 35 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Laborer				10b. KIND OF BUSINESS OR INDUSTRY New Jersey		11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Will Robinson					14. MOTHER'S MAIDEN NAME Maggie Hendley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. U.S. Army, WWII		17. INFORMANT Patient		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Traumatic Aortic Insufficiency, Post-op. 936.9 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) } DUE TO (c) }									INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Chest crushed while unloading heavy box						
20c. TIME OF INJURY Month, Day, Year Apr. May 1960			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) Unknown (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Brosch M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) FRANK J. Brosch					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12-8-60		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF Dec. 13, 1960		22c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		22d. LOCATION (City, town, or country) (State) Blountfield, N.Y.		
23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Md.					24a. REC'D BY REGISTRAR DEC 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks		

MEDICAL CERTIFICATION

14128 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE
STATE OF
MISSISSIPPI

County of _____
State of _____
I, _____
do hereby certify that _____
was born _____
and died _____
at _____
on _____
at the age of _____
years, _____
months, and _____
days.

Witness my hand and seal
this _____ day of _____
A.D. 19____, at _____
in the County of _____
State of _____.

My commission expires _____
at _____
in the County of _____
State of _____.

Subscribed and sworn to before me
this _____ day of _____
A.D. 19____, at _____
in the County of _____
State of _____.

Notary Public for the State of _____
My commission expires _____
at _____
in the County of _____
State of _____.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>14424-Rosedale Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Alice</i> Last <i>Rogers</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>31</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 23, 1884</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home-maker</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Houtzdale, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Brady</i>		14. MOTHER'S MAIDEN NAME <i>Rose Timberling</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Rose Marie Rogers</i>		Address <i>Same As Above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i> <i>14 years</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-10</i> 19 <i>60</i> to <i>12-31</i> 19 <i>60</i> , that (I) (we) lost saw the deceased alive on <i>12-31</i> 19 <i>60</i> , and that death occurred at <i>5:20</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Michel M. Healy</i>		22b. DATE SIGNED <i>12/31/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Michel M. Healy</i>		22d. ADDRESS <i>5523 Trent St. Chevy Chase, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/3/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Lawrence Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Houtzdale, Penna.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR <i>JAN 3 '61</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kross</i>	

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CERTIFICATE OF DEATH

14180

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Robert A. Pashinsky, husband of Mary Ann Pashinsky, born [illegible]
at Lawrence, Kentucky, died at [illegible] [illegible] [illegible]
Michael N. Healy, born [illegible] [illegible] [illegible] [illegible] [illegible]
3552 Street St. Grove Chase, Md.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY William	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 34 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Lawrence Last ROONEY		4. DATE OF DEATH Month December Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-51
9. AGE (In years lost birthday) 9 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thomas ROONEY		14. MOTHER'S MAIDEN NAME Lucinda VAN METER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT John Thomas ROONEY		Address Qts 344 Quantico, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 Intracranial hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombocytopenia (c) Leukemia, acute		INTERVAL BETWEEN ONSET AND DEATH 48 hr. 2 wk. 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from Nov. 20 1960 to Dec. 24 1960 , that X (we) last saw the deceased alive on Dec. 24 1960 , and that death occurred at 8:15 AM , from the causes and on the date stated above.			
22a. SIGNATURE L.G. Thorne		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L.G. THORNE, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 28 December 60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE P. M. Thayer		25a. REC'D BY REGISTRAR DEC 29 '60	
ADDRESS Ives Funeral Home 2847 Wilson Blvd. Arlington, Va.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

111100

North Carolina, State of

County of Wake

City of Raleigh

John Thomas Smith

Male

Age 65

John Thomas Smith

John Thomas Smith, formerly of the County of Wake, State of North Carolina, died on the 10th day of May, 1968, at his residence, 1234 Elm Street, Raleigh, North Carolina.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

1

051

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14191

14147

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 35 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1709 D. Street, N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle ROSENBERG Last ROSENBERG				4. DATE OF DEATH Month December Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-24-92	
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68		11. IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min. 68		12. IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY U.S.Coast Guard		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Max Rosenberg				14. MOTHER'S MAIDEN NAME Sarah SINGMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWI - WWII				16. SOCIAL SECURITY NO. (W) Mrs. Ann L. Rosenberg, 5812 7th St., NW,			
17. INFORMANT WashDC				Address WashDC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) Stitcher attended the deceased from Dec. 8 19 60 to Dec. 8 19 60 , that (I) xx last saw the deceased alive on Dec. 8 19 60 , and that death occurred at 12:05 PM M, from the causes and on the date stated above.							
22a. SIGNATURE J. E. Stitcher				22b. DATE SIGNED 12-9-60			
22c. PHYSICIAN'S NAME (Type) J. E. STITCHER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-11-60			
23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cemetery				23d. LOCATION (City, town, or county) (State) Oxon Hill Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home				25a. REC'D BY REGISTRAR DEC 12 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. ...							

14101

Maritime

Postmaster (Rural)

32 min.

Washington

U. S. Naval Hospital

1709 D. Street, N. E.

Jacob

ROSENBERG

DETROIT

Unusually

2-24-52

60

Officer (Rural)

U.S. Coast Guard

ILLINOIS

USA

Max Rosenberg

GARY BINGMAN

WASDC

Yes - Will

(W) Mrs. Ann L. Rosenberg, 3012 7th St., NW

Pulmonary edema

1/2 hr.

Arteriosclerotic heart disease

acute

Diagnosis modified

XXXXXX

Dec. 8

Dec. 8

Dec. 8

2

12-9-50

x

U. S. STATION, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Maryland

Once Will

U. S. Naval Cemetery

12-11-50

Serial

Collier, Samuel Home, 4417 7th St., NW, WashDC

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14192

CERTIFICATE OF DEATH

Reg. Dist. No. 14148

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson--R.F.D.		c. LENGTH OF STAY IN 1b 8 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl William Rowe		4. DATE OF DEATH December 20 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15-1911
9. AGE (In years lost birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer--Bechtel Const Co.		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Rowe		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 224-12-7424	
17. INFORMANT Mrs Earl W. Rowe, Dickerson, R.F.D., Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 minutes 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Dec., 1960 , to 20 Dec., 1960 , that I last saw the deceased alive on 19 Dec., 1960 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED 12/20/60			
ACTUAL SIGNATURE Gordon M. Smith		M.D. Barnesville, Md	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/60	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Bearsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton		ADDRESS Barnesville Md	
24a. REC'D BY REGISTRAR DEC 23 '60		24b. REGISTRAR'S SIGNATURE Carroll E. Kneass	

CERTIFICATE OF DEATH

Montgomery

Maryland

Montgomery

Dickerson, R. F. D.

8 yrs

Dickerson--R. F. D.

7

December 30

William Rowe

Earl

March 15-1911

White

Male

U.S.

Virginia

Laborer--Bechtel Const Co.

Unknown

William Rowe

Mrs Earl W. Rowe, Dickerson, R. F. D., Md

224-12-7424

County of Prince George

City of Alexandria

12/30/50

Barnesville, Md

Gordon H. Smith

CERTIFICATE OF DEATH

Reg. Dist. No. 14149

14193

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York State b. COUNTY Long Island			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jamaica, Long Island			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 8715 165th St.			
3. NAME OF DECEASED (Type or print) First Leonard W. Middle Rutledge Last 				4. DATE OF DEATH Month Dec. Day 14 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/95	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contract Photographer-ret.			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Martin Rutledge			14. MOTHER'S MAIDEN NAME Mary Leonard				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Mexican		INFORMANT Thomas J. McCoy		Address 4606 Singleton Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TOXEMIA 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma (c) Ovarian Carcinoma Recurrence DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 58 days 2 mo. 6 mo.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 59 , to Dec 13 , 19 60 , that I last saw the deceased alive on Dec 13 , 19 60 , and that death occurred at 1:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8218 WINDOMER AVE DATE SIGNED 12/14/60							
ACTUAL SIGNATURE Leo I. Dowd		M.D. LEO I DOWD M.D.					
PHYSICIAN'S NAME (Type) LEO I DOWD M.D.		BETHESDA MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transir		22b. DATE THEREOF 12/17/60		22c. NAME OF CEMETERY OR CREMATORY St. Lawrence Cemetery		22d. LOCATION (City, town, or county) (State) Sayville, L.I. New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 20 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1 *X*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

074

(M)

(I)

2

1

12113

CERTIFICATE OF DEATH

12/17/76 St. Mary's Cemetery, Louisville, L.I. New York

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14194

CERTIFICATE OF DEATH

14150

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY PG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patrick Middle Michael Last RYAN		4. DATE OF DEATH Month December Day 3 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 September 1960
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Arnold Ryan		14. MOTHER'S MAIDEN NAME Dorothy Lee Cowher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph A. Ryan, 4945 Deal Dr., Washington 21, D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOXIA DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA, STAPHYLOCOCCUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal obstruction age 2 months.		INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 36 HOURS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2 December 1960 to 3 December 1960 , that (I) was lost saw the deceased alive on 3 December 1960 , and that death occurred at 1030A M, from the causes and on the date stated above.			
22a. SIGNATURE Robert V. Rack		22b. DATE SIGNED 3 December 1960	
22c. PHYSICIAN'S NAME (Type) Robert V. Rack, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/60	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		25. REC'D BY REGISTRAR DEC 6 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2051191XV 3

CERTIFICATE OF DEATH

11151

Minister of Columbia

Montgomery

Washington

1 day

Stethema (Hemol)

4045 Deal Drive

U. S. Naval Hospital

RYAN

Michael

Barlow

December 3

2 September 1900

Canadian

Male

1

Maryland

U.S.A.

Barclay Lee Coxner

Joseph Arnold Ryan

None

No

Joseph A. Ryan, 4045 Deal Dr., Washington 25, D.C.

WYOMING

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-80 BY SP-6 JRS/ML

2 December 00 1 December 00

1904

2 December 00

2 December 1900

U. S. Naval Hospital, Bethesda, Md.

Robert V. Pack, D.M.S.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14053

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence prior to admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>8527 11th Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Forte</u> Last <u>Sandison</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-83</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Sandison</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Chapman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>W.S. Hospital Records</u>			
17. INFORMANT Address <u>W.S. Hospital Records</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u> </u>							
DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
① Coronary artery Sclerosis ② Probable Multiple myeloma							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 24, 1960</u> to <u>Dec. 26, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 26, 1960</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Gene U. Cohen, M.D.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec. 26, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gene U. Cohen, M.D.</u>				22d. ADDRESS <u>931 Pershing Drive Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Faithful</u>		23d. LOCATION (City, town or county) (State) <u>md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Thoms</u> ADDRESS <u> </u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 3 1961</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14051



CERTIFICATE OF DEATH

Reg. Dist. No.

14152

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rapine Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hilda Darnall Sanford</u>		4. DATE OF DEATH <u>Dec 1 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 18, 1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Gov't Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip H. Darnall</u>		14. MOTHER'S MAIDEN NAME <u>Marian Sheirburn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Record. Rapine Nursing Home</u>		Address <u>Record. Rapine Nursing Home</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 33 IX DUE TO Conditions, if any which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>3 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/29, 1960</u> to <u>12/1, 1960</u> that I last saw the deceased alive on <u>11/29, 1960</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Rockville Rd. Rockville, Md.</u> DATE SIGNED <u>12/1/60</u>			
ACTUAL SIGNATURE <u>Herman C. Maganzini</u> M.D.		DATE SIGNED <u>12/1/60</u>	
PHYSICIAN'S NAME (Type) <u>809 Rockville Rd. Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kirkie Drew Thibodeau</u> ADDRESS <u>7th</u>		24a. REC'D BY REGISTRAR <u>DEC 12 1960</u> 24b. REGISTRAR'S SIGNATURE <u>H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14107

[Faint, mostly illegible handwritten text, likely a death certificate form. The text is mirrored across the page, suggesting bleed-through from the reverse side.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14196

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14153

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>				c. LENGTH OF STAY IN 1b <i>23 Silver - Springs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wheaton Nursing Home</i>				d. STREET ADDRESS <i>125 E. Wayne Ave. Apt. 512</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>Thomas</i> Last <i>Santmyers</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>26</i> Year <i>1960</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 15 - 1890</i>		9. AGE (In years last birthday) <i>70</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <i>Architect</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Williams</i>				14. MOTHER'S MAIDEN NAME <i>Katheryn Sacks</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-34-8350</i>		17. INFORMANT <i>Dorothy Santmyers - Same #2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA, STOMACH & METASTASES</i> DUE TO (b) <i>EMPHYSEMA, PULMONARY</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>6 MONTHS</i> <i>10 YEARS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>12-20</i> , 19 <i>60</i> , to <i>12-26</i> , 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>12-30</i> , 19 <i>60</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Philip R. James</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>Philip R. James</i>	
22d. ADDRESS <i>5401 Western Ave., N.W. Wash. 15, D.C.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/28/1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>				25a. REC'D BY REGISTRAR <i>DEC 29 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14154

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE GERMANY GERMANY b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMBURG d. STREET ADDRESS 39 WINTERHEDER KAI			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1840 EAST-WEST HIGHWAY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GERTRUDE ELISE HENRIETTE SAUER				4. DATE OF DEATH Month DEC. Day 20 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/01	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) HAMBURG, GERMANY	
12. CITIZEN OF WHAT COUNTRY? GERMANY							
13. FATHER'S NAME HEINRICH PAYSSEN				14. MOTHER'S MAIDEN NAME EMILIE GLASHOFF			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Luther K. Baughams, 1840 East-West Hwy. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCHART				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL				22b. DATE THEREOF 1/5/61		22c. NAME OF CEMETERY OR CREMATORY HAMBURG, GERMANY	
23. FUNERAL DIRECTOR WARNER E. PIMPHREY, INC. Raymond A. Jaska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DEC 27 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

12-20-60

HEALTH UNIT
JAN 27 1961

14016

MEDICAL EXAMINER - CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH

LOCAL HEALTH DEPARTMENT - NEW YORK CITY

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

SEX: [illegible]

AGE: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

SEX: [illegible]

AGE: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

SEX: [illegible]

AGE: [illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14197

14155

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle R Last SCHMITT				4. DATE OF DEATH Month DEC. Day 11 Year 1960			
5. SEX MALE	6. COLOR OR RACE WH ITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/97	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME ROBERT F. SCHMITT			14. MOTHER'S MAIDEN NAME EMMY PABST				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. WORLD WAR I		17. INFORMANT Blanche E. Schmitt WIFE (SAME AS ABOVE) # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema + Cardiac failure DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO (c) Primary Pulmonary Adenocarcinoma							INTERVAL BETWEEN ONSET AND DEATH 10 hrs 5 mo 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1960 to Dec 11, 1960 that (I) (we) last saw the deceased alive on Dec 11, 1960 and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE Robert G. Taylor				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) ROBERT G. TAYLOR	
22d. ADDRESS Washington Clinic Washington 15, D.C.				22e. REC'D BY REGISTRAR DEC 14 '60		22f. REGISTRAR'S SIGNATURE Arthur S. Hines	
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF 12/14/60		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE A. Hines Co.				25. ADDRESS 2901 14th NW			

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1

CERTIFICATE OF DEATH

14193

DEPARTMENT OF JUSTICE

U.S.

NAME OF DECEASED

JOHN EDWARD BROWN

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

LOCALITY

CAUSE OF DEATH

IMMEDIATE CAUSE

DECEASED WAS
AT THE TIME OF DEATH

DECEASED WAS
AT THE TIME OF DEATH

X

SIGNED AND SEALED
AT THE CITY OF
WASHINGTON
THIS 14TH DAY OF
JANUARY 1914

14054

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14156

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>5 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium & Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>LOTA LOTA FERN Schofield</i>				4. DATE OF DEATH <i>12 - 14 1960</i>			
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-3-89</i>	9. AGE (In years last birthday) <i>71</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cake Decorator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i>		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William H. Hardman</i>				14. MOTHER'S MAIDEN NAME <i>Emma Rea</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Washington Sanatorium & Hospital</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.1 DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>one month</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>October 24, 1960</i> to <i>Dec 14, 1960</i> , that (I) (we) last saw the deceased alive on <i>Dec 13, 1960</i> , and that death occurred at <i>7:45 A</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Boris Roblein</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Dec 14, 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>BORIS RABKIN</i>				22d. ADDRESS <i>1019 University Blvd. S. S. Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Entombment</i>		23b. DATE THEREOF <i>Dec 16, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Mausoleum</i>		23d. LOCATION (City, town, or county) (State) <i>Prince George Co Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Naltus</i>				25a. REC'D BY REGISTRAR <i>DEC 19 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

11024

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of birth
7. Place of death
8. Cause of death
9. Signature of physician
10. Signature of registrar
11. Date of registration

14075

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14157

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>WASH. D.C.</i> b. COUNTY <i>47X-3</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				c. LENGTH OF STAY IN 1b <i>7 1/2 mos</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens San.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>ELEANOR</i> Middle <i>B.</i> Last <i>SHANNON</i>				4. DATE OF DEATH Month <i>12</i> Day <i>31</i> Year <i>1960</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 24, 1891</i>	
9. AGE (In years lost birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>15</i> Hours <i>5</i> Min.		IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Defense Dept.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>			
11. BIRTHPLACE (State or foreign country) <i>Missouri</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Robert A. Shannon</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Griffith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Aldora S. Schmidt</i> Address <i>5603 2nd St. N.W. Washington, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> 332X DUE TO <i>Cerebral arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>15 yrs</i> (c) <i>15 yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>15 yrs</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 1960</i> to <i>Dec 31, 1960</i> , that (I) (we) last saw the deceased alive on <i>Dec 22, 1960</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Samuel M. Bageant</i> M.D.				22b. DATE SIGNED <i>12/31/60</i>			
22c. PHYSICIAN'S NAME (TYPE) <i>SAMUEL M. BAGEANT</i>				22d. ADDRESS <i>5600 N.H. Ave. Wash., D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>				23b. DATE THEREOF <i>1/3/61</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>				23d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Jones Co.</i>				25a. REC'D BY REGISTRAR <i>DATE JAN 5 '61</i>			
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

MEDICAL CERTIFICATION

14075

CERTIFICATE OF DEATH

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10/10/01 BY 60322 UCBAW/STP/STP

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to discern but appear to include:]

... of ...
... born ...
... died ...
... cause of death ...
... signed ...
... date ...
... place ...
... registrar ...

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14198

14158

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Rockville d. STREET ADDRESS 412 Anderson Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret B. Shannon			4. DATE OF DEATH Month Dec. Day 7 Year 1960				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH I/ 6/88	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Grley B. Neal				
14. MOTHER'S MAIDEN NAME Annalia Margaret Neal			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				
16. SOCIAL SECURITY NO. none			17. INFORMANT Jasper Shannon Address 412 Anderson Ave. Rockville MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO Coronary Arteriosclerosis (c) Indef					INTERVAL BETWEEN ONSET AND DEATH 72 hrs 72 hrs Indef		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 12/5/60 to 12/7/60 , that (I) (we) last saw the deceased alive on 12/7/1960 , and that death occurred at 4:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Stephen N. Jones		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/7/60			
22c. PHYSICIAN'S NAME (Type) Stephen N. Jones		22d. ADDRESS 809 Union Mill Rd. Rockville MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/10/60	23c. NAME OF CEMETERY OR CREMATORY Monocacy	23d. LOCATION (City, town, or county) Rockville MD	(State)			
24. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton		ADDRESS Barnesville, MD		25a. REC'D BY REGISTRAR DATE DEC 9 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Frank		

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14108

DEPARTMENT OF HEALTH

14108

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Reg. Dist. No. 14159

14199

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bldg. 124 Nat. Naval Med. Center				d. STREET ADDRESS 4414 Highland Ave.			
3. NAME OF DECEASED (Type or print) Louis		First R		Middle Shearer		Last 12	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 8, 1908	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 12 Days 22 Hours 19 Min. 60		IF UNDER 24 HRS. Months 12 Days 22 Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repair man		10b. KIND OF BUSINESS OR INDUSTRY Nat. Naval Med Cen.		11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey E. Shearer		14. MOTHER'S MAIDEN NAME Hattie Butler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Ella M. Shearer - same address		Address 4414 Highland Ave.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrall Edema DUE TO (b) Cerebrall Contusions DUE TO (c) Fracture of skull		INTERVAL BETWEEN ONSET AND DEATH hrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently fell from ladder	
20c. TIME OF INJURY Hour 12 a. m. 22 p. m. 19 60		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bldg. 124 N.N.M.C.		20f. (City or town) Bethesda (County) Montg. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/22/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1-193

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH
John Doe	1 day	Home
AGE	SEX	RACE
65	Male	White
EDUCATION	RELIGION	US BORN
High School	Methodist	Yes
PREVIOUS ILLNESS	CAUSE OF DEATH	IMMEDIATE CAUSE
Heart Disease	Myocardial Infarction	Coronary Thrombosis
DATE OF EXAMINATION	SIGNATURE OF EXAMINER	DATE OF EXAMINATION
Jan 15, 1938	[Signature]	Jan 15, 1938

General Examination
General Examination

Signature of Staff

Signature of Staff

Signature of Staff

12-1938

Signature of Staff

Signature of Staff

RECEIVED BY STATE DEPT. OF HEALTH
JAN 15 1938

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

14055

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14160

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1228 Eye Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carl Middle Reginald Last Sjostrom				4. DATE OF DEATH Month December Day 28 Year 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 29, 1892	
9. AGE (In years lost birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rug Service		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Paul R. Sjostrom			
14. MOTHER'S MAIDEN NAME Emma Wright				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War I			
16. SOCIAL SECURITY NO.				17. INFORMANT Washington Sanitarium & Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 581.1 DUE TO Alcoholic cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Cardiovascular Renal Syndrome 1 year (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity				INTERVAL BETWEEN ONSET AND DEATH 2 weeks Several days			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1960 to Dec 28, 1960 , that (I) (we) last saw the deceased alive on Dec 26, 1960 , and that death occurred at 11 PM , from the causes and on the date stated above.							
22a. SIGNATURE Oliver E. Thompson				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) OLIVER E THOMPSON	
22d. ADDRESS 1735 Eye St. N.W. Wash. D.C.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 30, 1960		23c. NAME OF CEMETERY OR CREMATORY Ford Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Prince George County, Md	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters				24b. ADDRESS 254 Carroll St. N.W. D.C.		25. REC'D BY REGISTRAR JAN 3 1961	
25a. REGISTRAR'S SIGNATURE William S. Thomas				25b. REGISTRAR'S SIGNATURE			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1900

1. Name of deceased *John J. Smith*
2. Sex *Male*
3. Age *45*
4. Date of death *April 10, 1900*
5. Time of death *10:30 AM*
6. Place of death *Home*
7. Cause of death *Heart Disease*
8. Nature of disease *Coronary Artery Disease*
9. Duration of disease *Several years*
10. Name of physician *Dr. J. H. Brown*
11. Name of attending physician *Dr. J. H. Brown*
12. Name of informant *John J. Smith*
13. Name of informant *John J. Smith*
14. Name of informant *John J. Smith*
15. Name of informant *John J. Smith*
16. Name of informant *John J. Smith*
17. Name of informant *John J. Smith*
18. Name of informant *John J. Smith*
19. Name of informant *John J. Smith*
20. Name of informant *John J. Smith*

CHIEF CLERK

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14200

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14161

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1hr. 15min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 409 Gaither St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Caroline		First		Middle		Last		4. DATE OF DEATH Month December 20 Day 19 Year 60							
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-8-20		9. AGE (In years lost birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator				10b. KIND OF BUSINESS OR INDUSTRY Atomic Energy Comm.				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George CORNWELL				14. MOTHER'S MAIDEN NAME Massie L. ODEN				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No If yes, give war or dates of service							
16. SOCIAL SECURITY NO. 213-16-0383				17. INFORMANT (M) Mrs. Massie Cornwell, 1023 Rockcrest Dr.								Address Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) xx attended the deceased from Dec. 20 19 60 to Dec. 20 19 60 , that (I) xx last saw the deceased alive on Dec. 20 19 60 , and that death occurred on Dec. 20 19 60 , from the causes and on the date stated above.															
22a. SIGNATURE William P. Baker				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN				22d. DATE SIGNED 12-21-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/23/60				23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City, town, or county) (State) Rockville Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				ADDRESS Tyson Wheeler Funeral Home, Rockville, Md.				25a. REC'D BY REGISTRAR DATE DEC 27 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

References

body of

• **Integrity**

Unpublished.

• *Journal of the American Medical Association* 273:1211-1212, 1995

CS-6-5C

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14201

CERTIFICATE OF DEATH

Reg. Dist. No. 14162

1. PLACE OF DEATH COUNTY <u>Montgomery</u> M X I		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7800 Hampden Lane, Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7800 Hampden Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>H</u> Last <u>Slaughter</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Gov't</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Robert Slaughter</u>	
14. MOTHER'S MAIDEN NAME <u>Augusta Bannester</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Louise T. Slaughter-wife-same 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> DUE TO (b) <u>coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arterio sclerotic heart disease 2 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> 19 <u>57</u> to <u>Dec 24</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 23</u> 19 <u>60</u> , and that death occurred at <u>7:40</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Dec 24, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	24a. REC'D BY REGISTRAR <u>DEC 29 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

14301

Place 1932

7800 Hampton Lane, Baltimore, Maryland

7800 Hampton Lane

Let. 2, 1930

Virginia

Baltimore

U. S. Gov't

Arthur H. Hanger

Robert Hanger

James W. Hanger - 1932

None

None

James Hanger & Co., Inc.

Robert A. Hanger, Baltimore, Maryland

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14202

14162

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Milwood Farms		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4201 Warren St. N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle LOUIS Last SMITH		4. DATE OF DEATH Month Dec Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1898
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 9 Days 10	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dentistry	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles L. Smith		14. MOTHER'S MAIDEN NAME Annie Mullens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WW 1 WW 1		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alma G. Smith-wife-same 2d		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive vascular disease.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from MARCH 1960 to DEC 31, 1960 , that (I) (we) last saw the deceased alive on DEC 30, 1960 , and that death occurred at 4:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Earl H. Mitchell		22b. DATE SIGNED 12/31/60	
22c. PHYSICIAN'S NAME (Type) EARL H. MITCHELL		22d. ADDRESS 2029 Q St. N.W. Washington D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR Jan 3 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
14203
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
14164

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 40 min.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS 68 Coral Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jean Middle Carol Last SMITH		4. DATE OF DEATH Month December Day 10 Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-59
9. AGE (In years last birthday) yrs. 11		IF UNDER 1 YEAR Months 11 Days 10 Hours 10 Min. 18X-2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Larry Gene SMITH		14. MOTHER'S MAIDEN NAME Mary Lynn HEYDT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Larry G. Smith, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adrenal insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) meningococcal septicemia DUE TO (c) 24 HOURS INTERVAL BETWEEN ONSET AND DEATH 6 HOURS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from Dec. 10 1960 to Dec. 10 1960 , that (I) last saw the deceased alive on Dec. 10 1960 , and that death occurred at 8:46AM M, from the causes and on the date stated above.			
22a. SIGNATURE Robert V. Rack		22b. DATE 12-10-60	
22c. PHYSICIAN'S NAME (Type) Robert V. RACK LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 12-11-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City, town, or county) (State) Hayfield Minnesota	
24. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home, 131 11th St. S.E., WashDC		25a. REC'D BY REGISTRAR DEC 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

2051212XV 5

14808

12/10/50

Washington Post

40 min.

Barbados (Rural)

60 Carol Place

U. S. Naval Hospital

SMITH

Carol

John

12-30-50

Caucasian

Female

Maryland

Larry Carr Smith

Harry Lynn Wray

(F) Larry G. Smith, name as above

None

No

Dec. 10 1950

Dec. 10 1950

Robert V. Rack in MD 1031

U.S. Naval Hospital, Bethesda, Md.

Barbados, B.W.I.

Bayfield

Minnesota

Barbados, B.W.I.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14076

14165

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN lb 3 1/2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) KENSINGTON GARDEN SANITARIUM				d. STREET ADDRESS 35 WEST IRVING STREET			
3. NAME OF DECEASED (Type or print) First LILLIAN Middle LEE Last SMITH				4. DATE OF DEATH Month DECEMBER 17 Day 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7, 1882		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER OWN HOME RETIRED ---				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) ROANOKE, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME LEE W. SQUIRES			
14. MOTHER'S MAIDEN NAME SARAH EMMA AIRHEART AIRHART				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT WM. LEE SMITH, 9506 CULVER ST., KENSINGTON, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO Generalized arteriosclerosis (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/14/60 to 12/17/60 , that (I) (we) last saw the deceased alive on 12/16/60 and that death occurred at 4 P. M. from the causes and on the date stated above.							
22a. SIGNATURE W. T. Joyon				22b. DATE SIGNED 12/18/60			
22c. PHYSICIAN'S NAME (Type) WILLIAM T. JOYCE				22d. ADDRESS 8106 MAPLE RIDGE ROAD, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF DEC. 20, 1960		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	
23d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S COUNTY, MD.				23e. REC'D BY REGISTRAR DEC 23 '60			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Poiry, INC., 8434 Ga. Ave., Silver Spring, Md.				25. REGISTRAR'S SIGNATURE Arthur S. Kirsch			

CERTIFICATE OF DEATH

12070

DECEASED

DECEASED

DECEASED

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

DECEASED

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U.S. Army Medical Center, Bethesda, Md.

Arlington National Cemetery, Arlington, Virginia

First W. GREGG, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

10-2-60

x

4:20AM

Nov. 2

Dec. 2

60

Dec. 2

x

60

U.S. Army Medical Center, Bethesda, Md.

Myocardial infarction, left ventricle with widespread
necrosis

No Name (P) Robert B. Smith, age 42, above

Robert B. SMITH

HEMORRHOID DYSPLASIA

U.S.A. Indiana

Male Caucasian

x

5-7-48

10

Decem 2

60

Robert

Brace

SMITH

U. S. Naval Hospital

50 Westland Drive

33 days

Hampton

Nebraska (Rural)

Virginia

Memorandum

14204

CERTIFICATE OF DEATH

AMERICAN RED CROSS - NATIONAL HEADQUARTERS - WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

14205

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14167

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONTGOMERY GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>13X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>REBECCA</u> Last <u>SNOWDEN</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>1</u> Year <u>1960</u>	
S. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>9-28-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>77</u> yrs.
13. FATHER'S NAME <u>GRAFT HOLLAND</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH WHITE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>HOSPITAL RECORDS, OLNEY, MARYLAND</u>	
17. INFORMANT <u>HOSPITAL RECORDS, OLNEY, MARYLAND</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE INTO PONS</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>MYOCARDIAL INFARCTION</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MYOCARDIAL INFARCTION - 5 DAYS</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>36 HOURS</u> <u>36 HOURS</u> <u>5 DAYS</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 30, 1960</u> to <u>DEC 1, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 30, 1960</u> , and that death occurred at <u>2:40 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. S. Whitaker, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>C. S. WHITAKER, M. D.</u>		22d. ADDRESS <u>CLARKSVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/5/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Chapel.</u>		23d. LOCATION (City, town, or county) (State) <u>Highland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>DEC 7 '60</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

14205

CERTIFICATE OF DEATH

14205

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
100 STATE STREET, ROOM 1000, BOSTON, MASSACHUSETTS 02109

DATE OF DEATH: _____
TIME OF DEATH: _____
PLACE OF DEATH: _____
AGE: _____
SEX: _____
RACE: _____
MARRIAGE: _____
OCCUPATION: _____
EDUCATION: _____
RELIGION: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF REGISTRAR: _____
SIGNATURE OF DECEASED: _____
SIGNATURE OF WITNESSES: _____
SIGNATURE OF PHYSICIAN: _____
SIGNATURE OF CLERGY: _____
SIGNATURE OF FUNERAL HOME: _____
SIGNATURE OF NEXT OF KIN: _____
SIGNATURE OF POLICE: _____
SIGNATURE OF JUDGE: _____
SIGNATURE OF DISTRICT ATTORNEY: _____
SIGNATURE OF COUNTY CLERK: _____
SIGNATURE OF TOWN CLERK: _____
SIGNATURE OF VOTING CLERK: _____
SIGNATURE OF SCHOOL CLERK: _____
SIGNATURE OF CHURCH CLERK: _____
SIGNATURE OF SYNAGOGUE CLERK: _____
SIGNATURE OF MOSQUE CLERK: _____
SIGNATURE OF TEMPLE CLERK: _____
SIGNATURE OF OTHER CLERK: _____

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G277 12-28-60 et

14168

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>1653-2</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		d. STREET ADDRESS <u>1615 Amherst Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMERY MARTIN SONDHEIMER</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>16</u> Year <u>1960</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-16-1898</u>		9. AGE (In years last birthday) <u>62</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Terminal</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>NATHAN SONDHEIMER</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Tappen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES 1st World War</u>	
16. SOCIAL SECURITY NO. <u>718-18-0125</u>		17. INFORMANT <u>Mrs. Alice H. Sondheimer</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-17-60</u>	
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-20-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or country) <u>Suitland Md.</u>		23. FUNERAL DIRECTOR <u>Lee Funeral Home - Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>DEC 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		VS. A15ME 5M 7/59									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000
100-100000

14056

WORLD ALPHABETICALLY BY LAST NAME

1-100

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14169

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>51 Cherry Chase</u>			
c. LENGTH OF STAY in 1b <u>10 yrs</u>				d. STREET ADDRESS <u>17710 Curtis st</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7710 Curtis st.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Francis Splain</u>				4. DATE OF DEATH <u>Dec 19 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARried <input checked="" type="checkbox"/> NEVER MARried <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-1884</u>	
9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Com. for D.C.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Splain</u>				14. MOTHER'S MAIDEN NAME <u>Catharine Spellman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give word dates of service)				16. SOCIAL SECURITY NO. <u>6015 Western Ave Wash. D.C.</u>			
17. INFORMANT <u>Robt Splain (son)</u>				Address <u>6015 Western Ave Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> (e), stating the underlying cause last. <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12-19-60</u>			
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETARY</u>		22d. LOCATION (City, town, or country) (State) <u>WHEATON MARYLAND</u>	
23. FUNERAL DIRECTOR <u>Timothy Haulon</u>				24a. REC'D BY REGISTRAR <u>4748-Wisc. Avenue</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

VS. A15ME
SM 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-11-1910

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10-11-1910

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14057

CERTIFICATE OF DEATH

14170

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>146 XXXXX XXXXX, SILVER SPRING</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San + Hosp</u>				e. STREET ADDRESS <u>277 W. Notley Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Elmer Paul Steigner</u>				4. DATE OF DEATH <u>12-26-60</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-98</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Montg. Blair High School</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Theodore Steigner</u>				14. MOTHER'S MAIDEN NAME <u>Emma Moatz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1st World War</u>				16. SOCIAL SECURITY NO. <u>214-03-8240</u>			
17. INFORMANT <u>Mrs. Elizabeth R. Steigner, 277 W. Notley Rd. Silver Spring, Md</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c) <u>1</u> DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Silver Spring, Md</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1950</u> to <u>Dec. 26</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Dec. 20</u> , 19 <u>60</u> , and that death occurred at <u>11:20 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. B. Wardrop MD</u> M.D.				22b. DATE SIGNED <u>12/26/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. B. WARDROP</u>				22d. ADDRESS <u>800 Pershing Drive Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/29/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>JAN 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

14057

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14206		14171	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>District of Columbia</i> b. COUNTY <i>Columbia</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	c. LENGTH OF STAY IN 1b <i>7 mo.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wheaton Nursing Home</i>		d. STREET ADDRESS <i>1342 Somerset Place, n.w.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Henri</i> Middle <i>-</i> Last <i>Stein</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>28</i> Year <i>1960</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR. 15-1888</i>
		9. AGE (In years last birthday) <i>72</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Lewis Baxd</i>		14. MOTHER'S MAIDEN NAME <i>Rose Norvic</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. Esther R. Miller</i> Address <i>1342 Somerset Place, n.w.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arterio-sclerosis</i> DUE TO (c) <i>Generalized arterio-sclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic epilepsy</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5/2/1960</i> to <i>12/28/1960</i> , that (I) (we) last saw the deceased alive on <i>12/27/1960</i> , and that death occurred at <i>2:35 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter K. Angevine</i>		22b. DATE SIGNED <i>12/28/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>WALTER K. ANGEVINE</i>		22d. ADDRESS <i>6300-13th St. N.W., Wash. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>12/24/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>UNITED HEBREW CEM.</i>	23d. LOCATION (City, town, or county) (State) <i>HALETHORPE. MD.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Gedberg Funeral Home</i>		25a. REC'D BY REGISTRAR <i>DEC 29 1960</i> ADDRESS <i>4217-9th St. N.W.</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-1-1956

TO THE
MANAGER
CENTRAL BANK OF INDIA
MUMBAI
FROM
THE
MANAGER
CENTRAL BANK OF INDIA
MUMBAI
SUBJECT: *[Faint text]*

[Faint signature and text at the bottom of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **14172**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4503 Walsh Street =				d. STREET ADDRESS 4503 XXXX Walsh Street			
3. NAME OF DECEASED (Type or print) First Middle Last ESTELLE ELIZABETH STEVENS				4. DATE OF DEATH Month Day Year Dec. 21, 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 30, 1926		9. AGE (In years last birthday) 34 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Jacksonville, Fla.	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Claude T. Hunt			14. MOTHER'S MAIDEN NAME Elva ? (Unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Robert Stevens-Husband-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO Hanging Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung self with belt from shower curtain rod in bath-room.					
20c. TIME OF INJURY Hour o. m. p. m. Noon 12/21 19 60	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Chevy Chase, Montg, Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/21/60			
EXAMINER'S NAME (Type) FRANK J. BROSCART							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			
22d. LOCATION (City, town, or county) (State) Rockville, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 27 1960		
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14173

FOR STATE
HEALTH DEPT.

14077

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Kensington</u>	
c. LENGTH OF STAY IN lb <u>2 yr</u>		d. STREET ADDRESS <u>10514 Parkwood Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10514 Parkwood Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles E. Stowers</u>		4. DATE OF DEATH <u>Dec 11 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1920</u> 39 yrs.
9. AGE (in years last birthday) <u>39</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Co</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>	
17. INFORMANT <u>Ruby Meyen</u>		Address <u>Itasca 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>9210</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pulmonary Stenosis</u> (a), stating the underlying cause lost. (c) <u>Aspiration of Gastric Contents</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Brought home at 4:15 P.M. and placed in bed. Found dead in A.M.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:15</u> Hour <u>4:15</u> p.m. <u>12-11</u> 19 <u>60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) (County) (State) <u>Montg.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-11-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

14057

INSTITUTIONAL DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is partially filled out with handwritten text and checkboxes.

Section 1: Patient Information
Name: [Handwritten Name]
Age: [Handwritten Age]
Sex: [Handwritten Sex]
Race: [Handwritten Race]
Address: [Handwritten Address]
Occupation: [Handwritten Occupation]

Section 2: Medical History
History of Present Illness: [Handwritten Description]
Past Medical History: [Handwritten List]
Family History: [Handwritten List]
Social History: [Handwritten List]

Section 3: Examination Findings
Vital Signs: [Handwritten Values]
General Appearance: [Handwritten Description]
Head and Neck: [Handwritten Findings]
Chest: [Handwritten Findings]
Abdomen: [Handwritten Findings]
Genitourinary: [Handwritten Findings]
Neurological: [Handwritten Findings]
Musculoskeletal: [Handwritten Findings]

Section 4: Cause of Death
Immediate Cause: [Handwritten Cause]
Underlying Cause: [Handwritten Cause]
Contributing Cause: [Handwritten Cause]

Section 5: Signatures and Dates
Physician: [Signature]
Medical Examiner: [Signature]
Date: [Handwritten Date]



Vertical text on the right margin, likely a filing or tracking number, and a date stamp.

FILED IN [Handwritten Number]
DATE [Handwritten Date]

14207

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14174

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 89 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tennessee b. COUNTY Memphis c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4002 Argonne St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Gunsauls STOWELL			4. DATE OF DEATH Month Day Year December 23 1960				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-23	9. AGE (In years lost birthday) 37 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Indiana			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Jay STOWELL				
14. MOTHER'S MAIDEN NAME Marie BLOMBERG			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII-Korea				
16. SOCIAL SECURITY NO. 561-26-0777			17. INFORMANT (W) Mrs. Margaret Stowell, same as #2 above				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embryoma, malignant, testis, with metastasis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sept. 25, 1960 to Dec. 23, 1960	(County) (State)			
21. I certify that (I) Hampton Hubbard attended the deceased from Sept. 25, 1960 to Dec. 23, 1960 , that (I) xx last saw the deceased alive on Dec. 23, 1960 , and that death occurred at 9:50AM M, from the causes and on the date stated above.							
22a. SIGNATURE Hampton Hubbard		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-23-60			
22c. PHYSICIAN'S NAME (Type) Hampton HUBBARD, CDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-27-60	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town, or county) (State) Arlington Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		ADDRESS WashDC		25a. REC'D BY REGISTRAR DEC 29 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Howard		

4.

(1999) 100

DOI: 10.1002/for

Robert.

122

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN lb 6 hours			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital				d. STREET ADDRESS 505 Cooks Lane			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Adelle Talley				4. DATE OF DEATH Month Day Year December 26 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1927	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days 33		IF UNDER 24 HRS. Hours Min. 33			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic worker				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) American	
13. FATHER'S NAME David Jackson				14. MOTHER'S MAIDEN NAME Louise Matthews			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no.				16. SOCIAL SECURITY NO. no.		17. INFORMANT Address Washington Sanitarium & Hospital Records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Bruschant M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BRUSCHANT				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 12-26-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/60		22c. NAME OF CEMETERY OR CREMATORY Good Hope.		22d. LOCATION (City, town, or country) (State) Colesville, Md.	
23. FUNERAL DIRECTOR Robert R. Swarden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 3 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

NOV 1941

UNITED STATES DEPARTMENT OF HEALTH
PUBLIC HEALTH SERVICE
BUREAU OF MEDICAL EXAMINERS
WASHINGTON, D. C.

REPORT

NOV 1941

NOV 1941

NOV 1941

NOV 1941

NOV 1941

NOV 1941

NOV 1941

1

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <u>8336-12th. Ave.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Gen. & Hosp.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Nionetta</u>						4. DATE OF DEATH <u>12</u> <u>9</u> <u>1960</u>					
First Middle Last						Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Chinese</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 23-16</u>		9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>China</u>					
11. BIRTHPLACE (State or foreign country)						12. CITIZEN OF WHAT COUNTRY? <u>—</u>					
13. FATHER'S NAME <u>Chum Hsiu Pe</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>Hosp Record</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u> <u>970.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Reported to have taken an overdose?</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-9-60</u>											
Address (Street, city, town, or county)											
22a. BURIAL (CREMATION) REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>Dec 14, 1960</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			
				22d. LOCATION (City, town, or country) (State) <u>Smithland, Md.</u>							
23. FUNERAL DIRECTOR ADDRESS <u>W.W. Tattavall 3603 14th St NW</u>											
24a. REC'D BY REGISTRAR <u>DEC 15 '60</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

MEDICAL CERTIFICATION

BP

THE STATE
OF NEW YORK

1907

1

RECEIVED
JAN 21 1907

OFFICE OF THE
COMMISSIONER OF
THE STATE DEPARTMENT OF
EDUCATION
ALBANY, N. Y.

TO THE
COMMISSIONER OF
THE STATE DEPARTMENT OF
EDUCATION
ALBANY, N. Y.

FROM
THE
SCHOOL OF
EDUCATION
AT
ALBANY, N. Y.

RE
YOUR
LETTER
OF
JANUARY
10, 1907

IN
REPLY
TO
YOUR
LETTER
OF
JANUARY
10, 1907

WE
ACKNOWLEDGE
THE
RECEIPT
OF
YOUR
LETTER
OF
JANUARY
10, 1907

AND
IN
ANSWER
TO
YOUR
LETTER
OF
JANUARY
10, 1907

WE
ADVISE
YOU
THAT
YOUR
LETTER
OF
JANUARY
10, 1907
HAS
BEEN
RECEIVED
AND
IS
BEING
CONSIDERED

VERY
RESPECTFULLY,
Yours,
J. M. W.

1
FOR STATE
HEALTH DEPT.
M
90
I
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15
2
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14177

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN b 2 yrs. 4 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CONGRESSIONAL MANOR SANITARIUM			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8720 COLESVILLE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY CHARLOTTE TAYLOR			4. DATE OF DEATH Month DECEMBER Day 5 Year 1960		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH MARCH 30, 1870		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER (retired)		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN ROACHE ROCHE		14. MOTHER'S MAIDEN NAME NANCY CRAW GRAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. OLIVE FLOUTON, 8720 COLESVILLE RD., SS., MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) WOUND INFECTION DUE TO (c) FRACTURED RIGHT HIP PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 22 days					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) FELL ON FLOOR AT SANITARIUM			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:50 NOV. 12 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SANITARIUM	
20f. (City or town) BETHESDA, MONTGOMERY, MARYLAND		20g. (County) MONTGOMERY		20h. (State) MARYLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEC. 5, 1960 ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. EXAMINER'S NAME (Type) FRANK J. BROSCART Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/8/60		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	
22d. LOCATION (City, town, or country) WASHINGTON, D.C.		22e. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22f. LOCATION (City, town, or country) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. <i>Raymond A. Ziska</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE DEC 12 '60	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>		24c. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>		24d. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14083

Reg. Dist. No. 14178

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>17 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty County Jail</u>			d. STREET ADDRESS <u>240 N. Washington St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Davis</u> First <u>Thomas</u> Middle <u>Thomas</u> Last			4. DATE OF DEATH <u>Dec</u> <u>16</u> <u>1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-1919</u>		9. AGE (in years last birthday) <u>41</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Unknown</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) [If yes, give war or dates of service]		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Police Record</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fat Embolism</u> DUE TO (b) <u>Hepatic Fatty Metamorphosis</u> DUE TO (c) <u>Chronic & Acute Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Unknown</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Chronic Subdural Hematoma</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Rockville</u>		20g. (County) <u>md.</u>		20h. (State) <u>md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>12-16-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>County Home Cem.</u>	
22d. LOCATION (City, town, or county) <u>Rockville</u>		22e. (State) <u>md.</u>		22f. (City, town, or county) <u>Rockville</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Mawder</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>					

HEALTH DEPT.
FOR STATE

11003

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DISEASE OR INJURY: [illegible]
LOCALITY: [illegible]

DATE OF EXAMINATION: [illegible]
PLACE OF EXAMINATION: [illegible]
NAME OF EXAMINER: [illegible]
SIGNATURE OF EXAMINER: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DISEASE OR INJURY: [illegible]
LOCALITY: [illegible]

DATE OF EXAMINATION: [illegible]
PLACE OF EXAMINATION: [illegible]
NAME OF EXAMINER: [illegible]
SIGNATURE OF EXAMINER: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DISEASE OR INJURY: [illegible]
LOCALITY: [illegible]

14209

CERTIFICATE OF DEATH

Reg. Dist. No. 14179

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington D.C. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Rockville 45 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverley Sanitarium		d. STREET ADDRESS 1319 Longfellow St., N.W.	
3. NAME OF DECEASED (Type or print) Ernest D. Thorne		4. DATE OF DEATH Month 12 Day 5 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1879
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery Business Friendly, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Albert Thorne		14. MOTHER'S MAIDEN NAME Ida E. Whitmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-28-7937	
17. INFORMANT LOUIS P. ALLWINE 11411 Rockville Pike Rockville Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the lung DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from May , 19 56 , to Dec 5 , 19 60 , that I last saw the deceased alive on Dec 5 , 19 60 , and that death occurred at 8 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Allen J. O'Neill		ADDRESS (Street, city or town, state) 8601 old Georgetown Rd	
PHYSICIAN'S NAME (Type) Allen J. O'Neill MD		DATE SIGNED Bethesda 19 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-8-1960	
22c. NAME OF CEMETERY OR CREMATORY Glennwood Cemetery		22d. LOCATION (City, town, or county) (State) Wash DC	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR DEC 8 '60	
ADDRESS 1661- Good Hope Rd SE Wash DC		24b. REGISTRAR'S SIGNATURE Charles S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Washington, D.C.

1945

DATE OF DEATH

TIME OF DEATH

12 3 40

PLACE OF DEATH

LOUIS BAIWINE
Rockville, Md

NO

CERTIFICATE OF DEATH

Reg. Dist. No. 14180

14210

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Roanoke			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 167 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2215 South Jefferson Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frances Middle Caroline Last Thornton				4. DATE OF DEATH Month December Day 6 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 October 1934	
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward G. Umberger				14. MOTHER'S MAIDEN NAME Fannie Radcliff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unascertainable			
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia and Hemothorax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pancytopenia DUE TO Choriocarcinoma with pulmonary, pelvic, vaginal, and bladder metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week 10 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 22 , 19 60 , to December 6 , 19 60 , that I last saw the deceased alive on December 6 , 19 60 , and that death occurred at 7:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/7/60 ACTUAL SIGNATURE Leo Stolbach, M.D. M.D. The Clinical Center PHYSICIAN'S NAME (Type) Leo Stolbach, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-transit 12-7-60				Evergreen Cemetery		Roanoke, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1-1-10

Residence

Virginia

Age

Marital Status

101 days

101 days

101 days

The Medical Center, Baltimore 11, Md. 21205 South Baltimore Street

1-1-10

December 2

Tombston

Caroline

Phonetic

28

21 October 1931

White

Female

U.S.A.

Virginia

None

Married

James H. H. H.

James H. H. H.

Under the authority of the Official Register, No. 11, 1931

2 days

Department and Hospital

1 week

1 week

10 months

Chronic disease with pulmonary, renal, cardiac, and other changes

and chronic changes

1-1-10 21 December 2-10-10

1-1-10 21 December 2-10-10

12/1/10

The Official Register

Official Register of Deaths

1-1-10 21 December 2-10-10

1-1-10 21 December 2-10-10

1-1-10 21 December 2-10-10

1-1-10 21 December 2-10-10

1-1-10 21 December 2-10-10

1-1-10 21 December 2-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14078											
14181											
1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MONTGOMERY</u> b. COUNTY <u>WASHINGTON, D.C.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington M.D.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>						d. STREET ADDRESS <u>5118 9th Street N.W.</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>TOMASULO</u> Last <u>TOMASULO</u>						4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1960</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/25/90</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tailoring</u>				11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Tomasulo</u>						14. MOTHER'S MAIDEN NAME <u>Marguerite Girardi</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Vincent J. Tomasulo</u> <u>1708 Donald Place Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>3 YRS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/30</u> 19 <u>58</u> to <u>12/27</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>60</u> and that death occurred on <u>12/27</u> 19 <u>60</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>David Blue</u> M.D.						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>HAROLD S. LINTH, M.D.</u>						22d. ADDRESS <u>1352 UNIVERSITY LANE</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>12/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines Co</u> ADDRESS <u>2901-14 St. M.W. Wash. D.C.</u>						25a. REC'D BY REGISTRAR <u>DEC 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

14058

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Date of registration: _____

MEDICAL CERTIFICATION

24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
DATE DEC 29 '60	<i>Arthur L. Hines</i>

1. 1990-1991
 2. 1991-1992
 3. 1992-1993
 4. 1993-1994
 5. 1994-1995
 6. 1995-1996
 7. 1996-1997
 8. 1997-1998
 9. 1998-1999
 10. 1999-2000
 11. 2000-2001
 12. 2001-2002
 13. 2002-2003
 14. 2003-2004
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 24. 2013-2014
 25. 2014-2015
 26. 2015-2016
 27. 2016-2017
 28. 2017-2018
 29. 2018-2019
 30. 2019-2020
 31. 2020-2021
 32. 2021-2022
 33. 2022-2023
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Page 4
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14061
14183
MAY 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Johns Hopkins Hospital</u>		d. STREET ADDRESS <u>11214 MARKWOOD DR. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Lewis</u> Last <u>SHAKER</u>		4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-09</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Med. Rep. Dome Chem Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York City</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel SHAKER</u>		14. MOTHER'S MAIDEN NAME <u>Ada Liverman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-07-0160</u>	
17. INFORMANT <u>St Hosp Record.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A. S. Ht Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> <u>1958</u> to <u>Dec 13</u> , 19 <u>60</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Dec 13</u> , 19 <u>60</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Leon L Gallin</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon L Gallin MD</u>		22d. ADDRESS <u>University Hills Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-15-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEM. GARDENS</u>		23d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Solberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>DEC 19 '60</u>			

CERTIFICATE OF DEATH

14001

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14211 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14184

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. General Hosp.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg Box 294			
d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George Washington				4. DATE OF DEATH Dec. 31, 1960			
5. SEX male				6. COLOR OR RACE col.			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 2/2/24			
9. AGE (In years last birthday) 36 yrs.				10. IF UNDER 1 YEAR Months Days			
11. IF UNDER 24 HRS. Hours Min.				12. CITIZEN OF WHAT COUNTRY? USA			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) MD.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henruetta Neal				14. MOTHER'S MAIDEN NAME Paul Turner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT Police Record				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of multiple lung abscesses (lt.) 493X DUE TO Conditions, if any, which gave rise to immediate cause (b) pneumonia (c) DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12/31/60			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-3-61			
22c. NAME OF CEMETERY OR CREMATORY Brownstown				22d. LOCATION (City, town, or country) (State) Germantown, Md.			
23. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville, Md.			
24a. REC'D BY REGISTRAR JAN 9 '61				24b. REGISTRAR'S SIGNATURE Anthony L. Kline			

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

1881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County of _____
City of _____
State of _____

On the _____ day of _____
A.D. 1881, at _____
I, _____
Medical Examiner,
do hereby certify that _____
aged _____ years,
sex _____,
was found _____
and died _____
at _____
the cause of death being _____
and the manner of death being _____

Witness my hand and seal this _____ day of _____
A.D. 1881.
At _____

Subscribed and sworn to before me this _____ day of _____
A.D. 1881.
At _____

Notary Public for the State of New York.
My Commission Expires _____
A.D. 1881.

14079

14185

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Edward Webb</u>				4. DATE OF DEATH Month Day Year <u>12 - 27 - 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3 '01</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>8 24</u>		11. IF UNDER 24 HRS. <u>8 24</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>special police agent - Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AKRON OHIO</u>			
11. BIRTHPLACE (State or foreign country) <u>AKRON OHIO</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William E. Webb</u>				14. MOTHER'S MAIDEN NAME <u>Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1919-1923</u>				16. SOCIAL SECURITY NO. <u>1919-1923</u>			
17. INFORMANT <u>Mrs. Myrtle Webb</u> Address <u>1212 Highwood Road, Rockville, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer - Bronchus - Bilateral</u> DUE TO <u>metastases to Mediastinum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Constrictive Heart Failure (terminal)</u> DUE TO <u>(terminal)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 mo.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1950</u> to <u>Dec 27, 1960</u> , that (I) (we) lost saw the deceased alive on <u>Dec 27, 1960</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>SAM ALLEN, M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>DEC. 27th, 1960</u>				22c. PHYSICIAN'S NAME (Type) <u>SAM ALLEN, M.D. 10407 Kensington, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>DEC. 30, 1960</u>			
23c. NAME OF CEMETERY <u>WASHINGTON NATIONAL CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hysong Co.</u> ADDRESS <u>WASH. D.C. 1300-N Street N.W.</u>				25a. REC'D BY REGISTRAR <u>DEC 28 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Curtis S. Kline</u>			

14033

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

IN SENATE
JANUARY 11, 1911
REPORT OF THE COMMISSIONER OF HEALTH

14017

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 12 Film 0276 12-13-60 et

14186

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <i>Maryland</i> b. COUNTY <i>BALTO.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRINGS, MD.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8103 Eastern Ave. N.W.</i>		d. STREET ADDRESS <i>6054 Falls Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>LENA</i> Middle <i>WEINSTEIN</i> Last		4. DATE OF DEATH Month <i>December</i> Day <i>4</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1887</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>HARRY RODMAN</i>		14. MOTHER'S MAIDEN NAME <i>GOLDIE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Eva Hart</i>		Address <i>2214 Ken Oak Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>420.0</i> IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Baltimore, Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 17, 1960</i> to <i>Dec. 17, 1960</i> , that (I) (we) last saw the deceased alive on <i>Dec. 17, 1960</i> , and that death occurred at <i>12:45</i> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Jules Gilbert</i>		22b. DATE SIGNED <i>12/4/60</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>3200 Chillum Rd., Mt Rainier, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>12/5/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Kneseth Israel Anshe Kolk</i>	23d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>SOL LEVINSON & BROS INC.</i>		25a. REC'D BY REGISTRAR <i>DEC 7 '60</i>	
ADDRESS <i>6010 Reisterstown Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>	



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STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1917

NAME OF DECEASED
RESIDENCE
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR
LOCAL HEALTH OFFICER
COUNTY CLERK

1

DECEASED
RESIDENCE
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR
LOCAL HEALTH OFFICER
COUNTY CLERK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14187

14212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9940 Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>I.</u> Last <u>Windsor</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1, 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fainter</u>		11. BIRTHPLACE (State or foreign country) <u>Urbana, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fainter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Urbana, Md.</u>	
13. FATHER'S NAME <u>Harry W. Windsor</u>				14. MOTHER'S MAIDEN NAME <u>Catherine F. Cain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>WW # 1 577-24-0666</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF LUNG</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>163X</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>59</u> , to <u>DEC 29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>DEC 28</u> , 19 <u>60</u> , and that death occurred at <u>8:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MAIN ST.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>G. F. Meadors</u> M.D.				PHYSICIAN'S NAME (Type) <u>G. F. MEADORS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan 3, 1961</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin T. W. Johnson</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 4 '61</u>			
ADDRESS <u>Damascus, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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BP

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14188

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN lb 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10,704 MALONE STREET				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNA ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAND BEACH d. STREET ADDRESS 02X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR MELVILLE WOLFE 4. DATE OF DEATH Month Day Year DEC. 28 1960															
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/1/92		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian, retired				10b. KIND OF BUSINESS OR INDUSTRY Bureau of Prisons U. S. Gov't.				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN L. WOLFE				14. MOTHER'S MAIDEN NAME ANNA L. GIBBONS											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. yes				17. INFORMANT Mr. John A. Wolfe, 10,704 Malone St. Silver Spring, Maryland				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of hypertension 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Frank J. Broschart				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12-28-60							
EXAMINER'S NAME (Type) FRANK J. BROSCART				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12/31/60		22c. NAME OF CEMETERY OR CREMATORY Oakfield Chapel Cemetery				22d. LOCATION (City, town, or country) (State) Hughesville, Maryland					
23. FUNERAL DIRECTOR Raymond E. Bumpirey, Inc.				ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR JAN 4 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

CERTIFICATE OF DEATH

Reg. Dist. No. 14189

14213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ironton 72X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 1628 1/2 South 3rd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Franklyn Zeek				4. DATE OF DEATH Month December Day 2 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1 1922		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Metal Work		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles D. Zeek				14. MOTHER'S MAIDEN NAME Myrtle Bryant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 233-30-2865		INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Insufficiency, post operative DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 27, 1960 , to December 2, 1960 that I last saw the deceased alive on December 2, 1960 , and that death occurred at 11:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/3/60 ACTUAL SIGNATURE William C. Awe M.D. The Clinical Center PHYSICIAN'S NAME (Type) William C. Awe M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-3-60		22b. DATE THEREOF 12-3-60		22c. NAME OF CEMETERY OR CREMATORY Zoar Cemetery		22d. LOCATION (City, town, or county) (State) Lawrence County, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE DEC 6 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

141313

UNITED STATES OF AMERICA

Ohio

Tolson

Walters

Belmont

The Director General

Long Beach, California

Re

San Francisco

Washington

Albany

San Francisco

Albany

Albany

San Francisco

Albany

San Francisco

Albany

San Francisco, California, January 11, 1951

San Francisco

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San Francisco